Family Planning and Reproductive Health Programs in Asia and the Near East

May 2002

U.S. Agency for
International Development

Bureau for Asia and the Near East

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Ellen Lynch, a New Entry Professional at USAID, created this document during her rotation with the Asia/Near East Bureau. Her compilation of statistics, indicator and trend data, and program descriptions for each ANE country provides an extremely useful regional overview, which the Bureau has decided to print and make available for distribution to interested audiences.

Contents

Introduction: Global and Regional Status of Family Planning and Reproductive Health

SAID Agency Goal

The USAID Agency goal of "world population stabilized and human health protected" recognizes that stabilization of rapid population growth and improved health and nutrition (particularly for mothers and children) are essential to sustainable development. By enabling people to control the size of their families, resources are made available at the household, national, and global levels for enduring improvements in quality of life. Moreover, improved health status of women and girls plays a critical role in child survival, family welfare, economic productivity, and population stabilization. This serves the U.S. national interest by contributing to global economic growth, a sustainable environment, and regional security. Reduced population pressures will also lower the risk of humanitarian crises in countries where population growth rates are highest.

A USAID objective of "unintended and mistimed pregnancies reduced" is driven by a development performance benchmark of total fertility rate reduced by 20 percent between 1998 and 2007.

Population, Health, and Nutrition (PHN) Results Framework Model

Population Vision

USAID's population program builds upon 35 years of leadership and impact in international family planning in collaboration with developing-country partners. It draws upon the values endorsed at the 1994 United Nations International Conference on Population and Development (ICDP) in Cairo to provide a broad range of reproductive health services, including, among others, safe pregnancy; control and prevention of sexually transmitted diseases (STDs) and HIV/AIDS; breastfeeding promotion; and women's nutrition.[1] It meets emerging needs and takes on new challenges in a rapidly changing world.

The program advances the multiple benefits of family planning – the empowerment of individuals to choose the number and spacing of births; enhanced maternal and child health; reduced incidence of abortion; and improved economic and environmental conditions through more sustainable rates of population growth.

The program contributes to the USAID goal of stabilizing population growth and protecting human health. In concert with USAID programs that focus on HIV/AIDS, maternal health, child survival, and other health issues, it also contributes to and benefits from the Agency's efforts to achieve broad-based sustainable development.

Vision Statement

With family planning as the core focus, the USAID population program will:

- Enable individuals and couples to exercise their right to avoid unintended pregnancy and other risks to reproductive health, including those associated with pregnancy, sexually transmitted infections (STIs), and HIV/AIDS
- Expand and sustain access to quality services, promote health behaviors, broaden contraceptive availability and choices, and strengthen policies and systems to address family planning and reproductive health needs
- Support gender equity and devote special attention to the underserved and those most at risk of adverse reproductive outcomes, including youth

[1] This range of services extended well beyond the focus on "family planning," which was usually equated with contraceptive services.

- Provide innovative technical leadership; foster collaborative relationships with local, national, and international partners; and forge linkages with other relevant sectors

The program embraces the core values of field orientation, voluntary and informed choice, empowerment of clients, evidence-based approaches, and measurable results.

Asia and the Near East

With 60 percent of the world's population located in Asia and the Near East (ANE), changes in average fertility rates in these areas have a tremendous impact on the size of the world's population. The average total fertility rate (TFR) for Asian and Near Eastern countries (excluding China) in 2001 was 3.2, nearly a 25 percent decline from a 4.3 average TFR in 1990. In countries that still have relatively high fertility rates, USAID has continued to make investments. Contraceptive prevalence in Asia and the Near East has increased sharply since 1990 and now averages 51 percent among married women ages 15 to 49.

The impact of family planning on maternal/child health has special relevance to the ANE region, where the lifetime risk of death from pregnancy averages 1 in 20 (compared with 1 in 9,000 in northern Europe). The United Nations Children's Fund (UNICEF) estimates that meeting all global family planning needs would prevent 175,000 maternal deaths annually and that the unmet need for family planning is greater in ANE countries than in any other region. Virtually all (99 percent) of maternal deaths occur in the developing world, and 56 percent of these occur in the ANE region.

USAID's ANE Bureau Priorities

USAID's regional priorities continue to be:

- The stabilization of population growth through reducing fertility
- Greater integration of health and family planning services to more fully address reproductive and maternal health needs
- The prevention of the rapid spread of HIV/AIDS

USAID also focuses on improving coordination and collaboration with other donors and promoting the sustainability of population, health, and nutrition (PHN) programs.

All regional USAID missions with PHN programs have strategic objectives (SOs) to reduce fertility, and most have SOs that include improving maternal and child health by reducing infant, child, and maternal mortality. Missions are addressing crosscutting themes in their PHN country programs; these include population momentum, access to quality services, and demand. With the exception of Morocco and Jordan, all ANE countries with USAID missions are implementing bilateral HIV prevention projects, utilizing USAID's particular strengths and experience in behavior change, social marketing, sentinel and behavioral surveillance, and policy formulation initiatives. USAID also implements a regional HIV/AIDS strategy, offering technical assistance to missions and providing oversight and funding to activities in non-USAID-presence countries such as Laos.

Strategies and Approaches

The last decade has witnessed a global trend toward integrated health and family planning programs. Customers prefer “one-stop shopping” – the ability to take care of a variety of health needs in a single visit. USAID mission programs are increasingly integrated, and integrated programs seem to be producing better results. Nepal is a good example of an integrated health and family planning program that includes literacy, empowerment, and income generation. In addition, informing prospective users of family planning about its important role in preserving maternal and child health challenges the perception that family planning programs are solely concerned with fertility control.

Sector policy reform has been a powerful tool in achieving success in fertility decline and improvements in family health. The experience from high-performing East Asian countries presents a compelling case for such policy reform. For example, policies mandating universal primary education and expanded secondary education, especially for women, generated rapid increases in labor force skills and contributed significantly to improved health and fertility decline. The now "graduated" countries of Thailand, Taiwan, and South Korea – all countries that no longer receive USAID assistance – are examples of such success. The Philippines, Indonesia, and Morocco are moving in this direction. Indonesia and Morocco have mature health and family planning programs and have prepared and started to implement transition plans to phase out bilateral programs in the PHN sector. In Morocco, the plan is proceeding on schedule, with transition to occur in fiscal year (FY) 2000. In Indonesia, however, the transition plan is no longer viable because of the country's financial and political crisis, and USAID/Indonesia will be developing a new PHN strategy that better reflects the current environment in the country.

The 1994 United Nations ICPD in Cairo called global attention to the key role of population and reproductive health issues in national development and the importance of female empowerment and education in achieving population stability. It greatly increased awareness among donors and governments of the need to address these issues. USAID missions are responding to this mandate by implementing programs more directly focused on reproductive health.

ANE missions work closely with donor partners to leverage resources, avoid duplication, and promote efficient packages of essential services. Collaboration with donors and host governments has positive long-term implications for sustainability. The ANE Bureau's primary donor partners in the PHN sector are UNICEF, the World Bank, the United Nations Population Fund (UNFPA), the Asian Development Bank (ADB), the United Kingdom's Department for International Development (DFID), the European Community (EC), and Japan through the U.S.-Japan Common Agenda.

Definition of Family Planning and Reproductive Health

Until the mid-1990s, the term "family planning" was widely interpreted to mean "contraceptive services." In the period leading up to and after the 1994 Cairo conference, there was pressure within the population community to broaden the constellation of services to respond to other reproductive health concerns of women. In addition, the target audience of family planning and reproductive health programs has since been enlarged to include adolescents and men.

"Family planning" is now regarded as a primary prevention strategy for maternal and newborn health that includes services targeting married and unmarried individuals and promoting delayed childbearing and birth spacing. Acceptance of family planning is greater when family planning services are integrated with maternal/child health, postpartum, and post-abortion care programs. In a UNFPA needs assessment in Pakistan, a lack of integration between family planning and other reproductive health services was cited as a significant obstacle to increasing the use of contraception. This contrasts with successes in Jordan and Tunisia, where postpartum care programs have provided needed follow-up for mothers and newborns while increasing subsequent use of modern family planning methods. Increased use of family planning has also been found among mothers practicing the lactational amenorrhea method, which is associated with higher rates of continuation with other family planning methods after breastfeeding stops. Post-abortion women who are counseled on family planning also have greater acceptance rates and fewer repeat abortions.

Common Indicators

Family planning programs are monitored to ensure that the expected results are achieved. Indicators commonly used to monitor performance of family planning programs are:

High-level (impact) indicator: Total fertility rate

Second-level (outcome) indicators: Contraceptive prevalence rate; couple-years of protection (CYP) (proxy)

Third-level (process) indicators:

Access/ Availability:	Access to family planning services Supply of contraceptives Trained providers Service delivery points
Quality:	Service delivery according to protocols Systems performance (training, supervision, logistics, stock-outs)
Demand:	Mean desired family size Desire to space or limit births Approval of family planning Knowledge of modern methods, location of services
Sustainability:	Public resource allocation for family planning Deregulation of family planning activities Mobilization of private sector Contraceptive social marketing

Legislation Affecting Family Planning Service Delivery

As previously stated, USAID's population policy is derived from the Agency's goal of "world population stabilized and human health protected." The Agency recognizes that to maintain and improve the health and nutrition of the world's population, it is essential to support programs that stabilize rapid population growth. This approach serves the U.S. national interest by contributing to global economic growth, a sustainable environment, and regional security.

In collaboration with developing-country partners, USAID's population programs have supported international family planning for 35 years. With the intention of ensuring quality family planning programs, Congress and presidential administrations have enacted laws or established policies that have implications for the delivery of family planning services. The most significant of these are the Tiahrt amendment and the "Mexico City policy" (sometimes referred to as the "global gag rule").

Tiahrt Amendment

In 1998, Congress enacted an amendment (known as the Tiahrt amendment after its author Representative Tiahrt of Kansas) to the FY 1999 Appropriations Act that legislated specific requirements for international family planning service delivery projects supported by USAID. The intent of the legislation is to protect family planning clients from coercion. The amendment was reenacted with the FY 2000 and FY 2001 Appropriations Acts and is expected to remain part of appropriations law for the foreseeable future.

While the principles of voluntarism and informed choice guide USAID's entire population program, the specific requirements of the Tiahrt amendment apply to projects that receive USAID development assistance (DA) funds and involve family planning service delivery activities. Under the Tiahrt amendment, a "project" is defined as a discrete activity through which a governmental or nongovernmental organization (NGO) provides family planning services to people and for which DA funds, or goods or services financed with DA funds, are provided. Specifically, the Tiahrt amendment directs that:

- Service providers and referral agents in family planning projects cannot implement or be subject to quotas relating to numbers of births, family planning acceptors, or acceptors of a particular family planning method.
- There be no incentives to individuals in exchange for becoming acceptors or to program personnel for achieving targets or quotas for numbers of

births, acceptors, or acceptors of a particular family planning method.

- Rights or benefits not be withheld from persons who decide not to become acceptors.
- Acceptors receive comprehensible information on health benefits and risks of the family planning method chosen, including known adverse side effects, and conditions that might make the method chosen inadvisable.
- Provision of experimental family planning methods occurs in the context of a scientific study in which participants are advised of potential risks and benefits.
- A single violation of the requirements of the Tiahrt amendment must be reported to Congress. In the case of the comprehensible information requirement, a pattern or practice of violations must be reported to Congress.

Mexico City Policy

The Mexico City policy announced by President Reagan in 1984 required NGOs to agree, as a condition of their receipt of federal funds, that they would neither perform nor actively promote abortion as a method of family planning in other nations. This policy was in effect until President Clinton rescinded it on January 22, 1993.

Under the policy as reinstated by President George W. Bush on January 22, 2001, foreign NGOs must certify that they will not perform or actively promote abortion as a method of family planning as a requirement for receiving population assistance for family planning activities under grants and cooperative agreements. Abortions provided in cases where the mother's life would be endangered if the fetus were carried to term and in cases of pregnancy following rape or incest are excluded from the requirement.

Country Briefs

The following pages contain a four- to five-page description of family planning/reproductive health programs in each of the listed ANE countries. Each brief includes indicators related to family planning and reproductive health followed by historical and background information on the country's development (especially as it pertains to family planning and reproductive health) and sections on USAID health programs and strategies, national health policy and plans, and other donors active in the country.

SOUTH ASIA

Bangladesh

India

Nepal

Pakistan

Bangladesh

Country Brief

USAID has been a key supporter of health and family planning programs in Bangladesh since 1972, providing more than $650 million in development assistance funding in this sector. USAID is the second largest donor in the population/health sector, after the World Bank and its partner consortium. U.S. partnerships with the Government of Bangladesh and local nongovernmental organizations in health and population have created one of the most successful population programs in the world. Areas of emphasis include behavior change, increased integration of health and family planning services, and improved quality, management, and sustainability of facilities and services. Current challenges include shifting service delivery from doorstep delivery to a facility-based approach and utilizing the potential of the private sector.

Indicators

Population	133.5 Million
Urban	21%
Crude Birth Rate	28 per 1,000
Crude Death Rate	8 per 1,000
Annual Growth Rate	1.6%
Adult Literacy Rate	Male: 49% Female: 26%
Government Agency for Population Policy	National Population Council
Maternal Mortality Ratio	596 per 100,000 live births
Births Attended by Trained Health Personnel	13%
DHS Years	1994,1997, 2000 (preliminary)
Source of Family Planning Supplies	Public programs: 65% Private sector: 29% NGO sector: 5%
Most Common Family Planning Method	Oral contraceptives

Background

Bangladesh's 133.5 million people – approximately half the United States' population – live in an area the size of Wisconsin. The country is located in the northeast corner of the South Asian subcontinent on a fertile river delta. With a population density of 2,401 people per square mile, it is one of the world's most densely populated countries. It is also one of the world's poorest countries. Some 36 percent of the population lives below the poverty line, with 68 percent of children affected by some form of malnutrition.

Despite the recent discovery of substantial natural gas reserves, Bangladesh continues to face enormous challenges in ensuring that food, energy, shelter, and other essential goods and services are available to its population, which is expected to surpass 200 million by 2035.

The United States has provided $4.5 billion in development assistance, food aid, and disaster relief to Bangladesh since the country became independent in 1971. Bangladesh is an important country for U.S. assistance, not only because of its size and need but also because of its potential as a leader of the moderate Islamic world and as a positive force for regional peace, stability, and growth in South Asia. U.S. foreign policy objectives in Bangladesh encourage stable democratic governance, respect for human rights, and market-oriented economic growth. The USAID program supports these foreign policy objectives and also serves U.S. global interests in stabilizing world population, eliminating hunger and food insecurity, protecting human health, and promoting environmentally responsible growth.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 1, Fertility Reduced and Family Health Improved, is supported by the following intermediate results (IRs): [Note: USAID/Bangladesh is currently in the process of revising its results package.]

IR 1.1: Increased use of high-impact elements of an "essential services package" among target populations, especially in low-per forming areas

IR 1.2: Increased knowledge and changed behaviors related to high-priority health problems, especially in low-performing areas

IR 1.3: Improved quality of services at National Integrated Population and Health Program (NIPHP) facilities

IR 1.4: Improved management of NIPHP service delivery organizations

IR 1.5: Increased sustainability of NIPHP service delivery organizations

U.S. partnerships with the Government of Bangladesh and indigenous nongovernmental organizations (NGOs) in health and population have created one of the most successful population programs in the world. As a result of the program's success, the contraceptive prevalence rate rose from 30 percent in 1986 to 54 percent in 2000, while fertility fell from 5.6 births per woman in 1987 to approximately 3.3 in 2000. USAID support for Bangladesh's Social Marketing Company has helped the company become one of the premier social marketing institutions in the world. The company supplies temporary methods of contraception and oral rehydration salts nationwide. In addition, oral rehydration therapy techniques developed with substantial USAID support in Bangladesh have saved lives all over the world by preventing deaths caused by cholera and other diarrheal diseases.

USAID has been a key supporter of health and family planning programs in Bangladesh since 1972, providing over $650 million in Development Assistance funding in this sector. Most of this funding has gone to the family planning program, which dominated the first two decades of USAID's population, health, and nutrition activities in Bangladesh. Consistent with changes in government policy, however, USAID's emphasis since

1997 has been on providing integrated health and family planning services via the "essential services package" (ESP). USAID supports 45 indigenous NGOs, assisted by two U.S. grantees, in providing the ESP through fixed and satellite clinics serving about 17 percent of the population.

USAID also supports improved program performance in the government sector through the development of an integrated management information system; operations research and technical assistance in family planning logistics; and selected child health initiatives, including immunization, vitamin A supplementation, and polio eradication. In recent years, USAID's funding has come from the Child Survival and Disease account and population-directed funds, reflecting this more balanced approach to sector programming.

Through its National Integrated Population and Health Program (NIPHP), USAID/Bangladesh has been the leader in implementing many of the reforms to integrate health and family planning services that emphasize the ESP while also gradually shifting away from doorstep service delivery to a facility-based approach. With the continuing need for improved and expanded health and family planning services, USAID should anticipate a continued major role in this sector in the future. A major challenge will be to better harness the efficiencies of the private sector in providing these services. Under NIPHP, USAID has started to implement this approach and will continue through 2010 to help the government shift its emphasis from providing services directly to regulating, supervising, evaluating, and financing the provision of services by private contractors and grantees.

USAID's major partners are the International Centre for Diarrhoeal Disease Research, Bangladesh, for operations research; Management Sciences for Health for technical support related to immunization and other child health services; EngenderHealth for quality improvement activities; John Snow, Inc., for urban service delivery and logistics management; and Pathfinder International for rural service delivery.

National Health Policy and Plans

Since its independence, Bangladesh has experienced significant changes in population size and growth. In 1971, the population numbered 73 million. The total fertility rate was 6.4 births per woman, which contributed to a population growth rate of 3.0 percent per year. The impressive success of Bangladesh's family planning program has reduced fertility to 3.3 births per woman and has slowed population growth to 1.6 percent per year.

These achievements are largely attributable to a service delivery strategy that compensated for restrictions on women's mobility by providing services at the client's doorstep. The country's less developed health services sector also adopted this strategy. In recent years, however, growing demand, limited resources, increased women's mobility, and the need to broaden the range of services to include long-term clinical methods required a major change in strategy. Current government policy is to provide the ESP through integrated health and family planning services, which were previously provided through separate programs with separate staffs and infrastructures. Health workers will gradually be placed in a greatly expanded number of community clinics that will provide all ESP services (family planning, maternal and child health, communicable disease control, and limited curative care). The progress of this transition has been slow, and satisfactory completion of the process will take time.

Other Donors

In 1999, USAID and the donor community provided new funding of about $1.9 billion for development activities in Bangladesh. The United States contributed just over 4 percent of this funding. Approximately 75 percent of donor assistance went into roads and transport, energy, agriculture and rural development, health and family welfare, water resources, education, and religious activities. Most of the major donor countries and agencies provide support to Bangladesh. The World Bank, the Asian Development Bank (ADB), Japan, the

European Union, and USAID are the five largest supporters of development activities in the country.

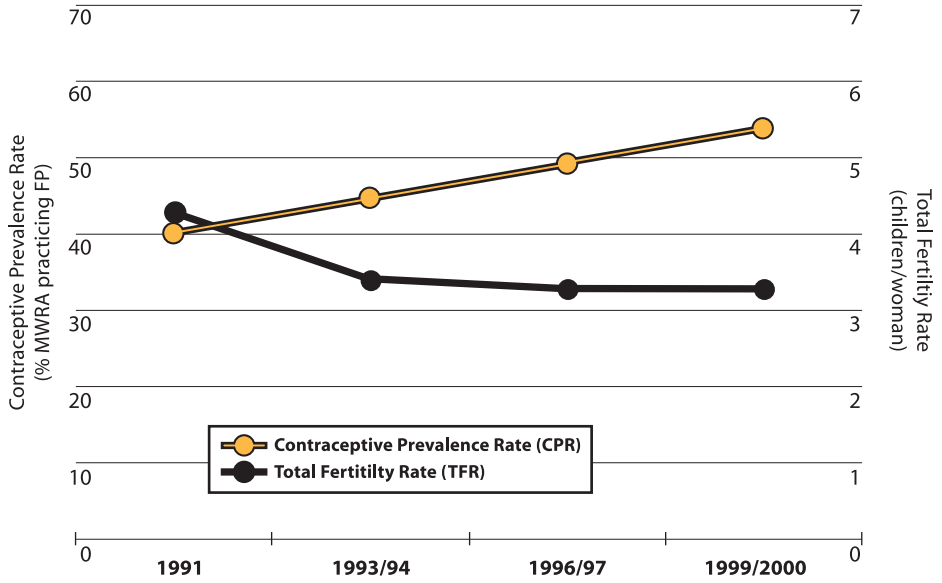
The Bangladesh government has adopted a sector-wide approach to managing and coordinating all donor inputs in the health sector. There is a 14-member donor consortium of nine bilateral and five multilateral donors. USAID is a member of the consortium, which focuses on a variety of systemic reforms in the government sector. These reforms are implemented under the World Bank's large Health and Population Sector Program (HPSP). USAID does not fund HPSP but coordinates closely with it. USAID, the U.K. Department for International Development, and ADB are the major donors supporting NGO activity in the sector, with each donor having clearly delineated and coordinated coverage areas.

Annual expenditures approach $80 million for integrated government services via the HPSP. UNICEF provides approximately $8 million of annual support for child survival and selected maternal health activities. Through the U.S./Japan Common Agenda, Japan has provided or committed more than $15 million since 1995 for the immunization program (primarily vaccines) and the expansion of family planning services through local governments. Future programming will focus on polio eradication, immunizations, reproductive and maternal health, infectious diseases, and improving vitamin A consumption. USAID is the second largest donor in the population/health sector, after the World Bank and its partner consortium.

Comments on this family planning/reproductive health country brief were received from the USAID/Vietnam office on 9/27/01.

Indicators and Trends

Contraceptive Prevalence and Total Fertility, 1991-2000



	1991	1993/94	1996/97	1999/2000
CPR (% MWRA)	39.9	44.6	49.2	53.8
TFR (child/woman)	4.3	3.4	3.3	3.3
Infant Mortality Rate (deaths/1,000 live births)		87.4	82.2	66.3

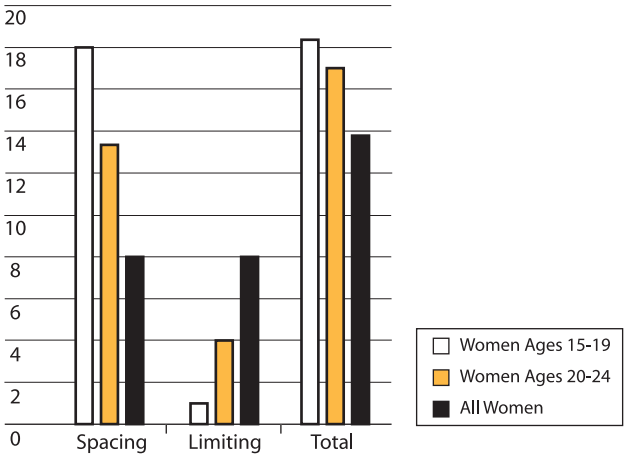
% Currently Married Women
Using Family Planning by Method, 1993/1994 – 1999/1997

	1993/1994	**1999/2000**
Any Method	44.6	53.8
Traditional	8.4	10.3
Modern	36.2	43.4
Method Mix		
Sterilization	(F) 8.1 (M) 1.1	(F) 6.7 (M) 0.5
Oral contraceptives	17.4	23
Condom	3.0	4.3
Injectables	4.5	7.2
Implants	N/A	N/A
IUD	2.2	1.2

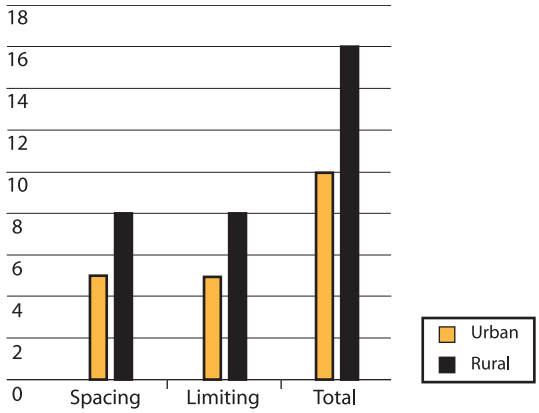
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

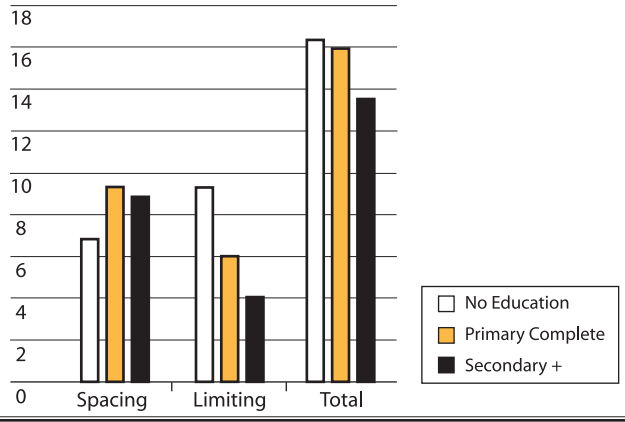
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

India

Country Brief

Since initiating assistance to the Government of India in 1951, USAID has provided $13 billion in food aid and development assistance. Fertility in India has declined during the 50 years of USAID assistance, but high fertility and poor reproductive health remain critical problems. The goal of USAID/India's family planning program is to improve the quality and use of reproductive health and family planning services in Uttar Pradesh state through training, social marketing, logistics, and behavior change. The World Bank also supports reproductive health services in Uttar Pradesh. Challenges that contribute to high fertility and rapid population growth include illiteracy, low status of women, and limited access to services.

Indicators

Population	1,033 Million
Urban	28%
Crude Birth Rate	26 per 1,000
Crude Death Rate	9 per 1,000
Annual Growth Rate	1.6%
Adult Literacy Rate	Male: 65% Female: 38%
Government Agency for Population Policy	National Commission on Population
Maternal Mortality Ratio	437 per 100,000 live births
Births Attended by Trained Health Personnel	42%
DHS Years	1993, 1999
Source of Family Planning Supplies	Public programs: 76% Private sector: 21%
Most Common Family Planning Method	Oral contraceptives

Background

Nearly 50 years ago, India became the first country in the developing world to initiate a state-sponsored family planning program aimed at lowering fertility and slowing population growth. Since the program's inception, fertility levels have steadily declined throughout the country, although at varying paces in different regions. Despite the overall decline, the reproductive health situation remains poor. The growth rate continues above replacement level, and India's population is expected to surpass China's by 2040.

Since its inception in 1951, India's National Family Planning Program has been dominated by demographic goals. In the mid-1960s, the central government introduced method-specific family planning targets and set goals for states to pursue at the local level. The program focused primarily on sterilization, severely restricting client choice and limiting availability to a narrow range of services. The program subsequently evolved into the Family Welfare Program, which today administers family planning and maternal/child health services through primary and community health centers and district and subdistrict hospitals.

In April 1996, the Indian government decided to abolish method-specific family planning targets throughout the country. In October 1997, the government reoriented the national program and radically shifted its approach in order to address health and family limitation needs more broadly. The new approach involves a more comprehensive set of reproductive and child health services and a focus on client choice, service quality, gender issues, and underserved groups, including adolescents, postmenopausal women, and men. The long-term objective of the new policy is to achieve a stable population by 2045.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 2, Reduced Fertility and Improved Reproductive Health in North India, is supported by the following intermediate results (IRs):

IR 2.1: Increased quality of public sector services in Uttar Pradesh

IR 2.2: Increased use of family planning services in Uttar Pradesh

IR 2.3: Increased use of reproductive health services in Uttar Pradesh

With a billion people, India accounts for 16 percent of the world's population. It adds a further 18 million people a year to its population, which represents one-fifth of global population growth. The purpose of the USAID Mission's SO 2 is to reduce the high level of fertility and improve women's reproductive health in northern India.

The major intervention under SO 2 is the Innovations in Family Planning Services (IFPS) activity in Uttar Pradesh, India's most populous state with 166 million people. The Program for the Advancement of Commercial Technology/Child and Reproductive Health complements IFPS and is designed to stimulate private sector participation and commercial partnerships for the development, promotion, and availability of reproductive health and child survival technologies.

Most program interventions under IFPS are targeted in 29 selected districts of Uttar Pradesh state. Activities across the state include training of medical personnel; contraceptive social marketing; contraceptive logistics; and information, education, and communication programs. Each intervention is tested on a small scale in selected areas or districts and, if it demonstrates sound potential, is scaled up in a phased manner to cover additional districts. The IFPS activity features an innovative performance-based disbursement system in which funds are only disbursed to the Indian government upon achievement of specific benchmarks.

The major grantees are the state's IFPS agency and ICICI Limited, which provides technical assistance for critical subgrantees. Technical cooperating agencies include EngenderHealth; CARE; the Center for Development and Population Activities (CEDPA); Johns Hopkins University; the Futures Group International; Deloitte Touche Tohmatsu; the University of North Carolina; Macro International, Inc.; the Program for Appropriate Technology in Health (PATH); the Population Reference Bureau; the Population Council; the U.S. Bureau of the Census; and John Snow, Inc.

National Health Policy and Plans

In March 2000, the Government of India promulgated a national population policy that espouses voluntary family planning, expansion of choices, and improved quality of services. All of these are consistent with U.S. policy and the IFPS project agreement, but the policy also contains provisions that may be construed as "incentives." A review of the policy by USAID/Washington and the Department of State has ascertained that the IFPS project is in compliance with U.S. law and policy.

The policy's guiding philosophy is that population control can be better achieved by improving conditions for people living below the poverty line, which will occur through a greater focus on such issues as child survival and health, illiteracy, empowerment of women, and increased participation of men in planned parenthood. The immediate objective of the policy is to address the needs for contraception, health care infrastructure, health personnel, and integrated service delivery. The medium-term objective is to bring the total fertility rate to replacement levels by 2010, and the long-term objective is to achieve a stable population by 2045.

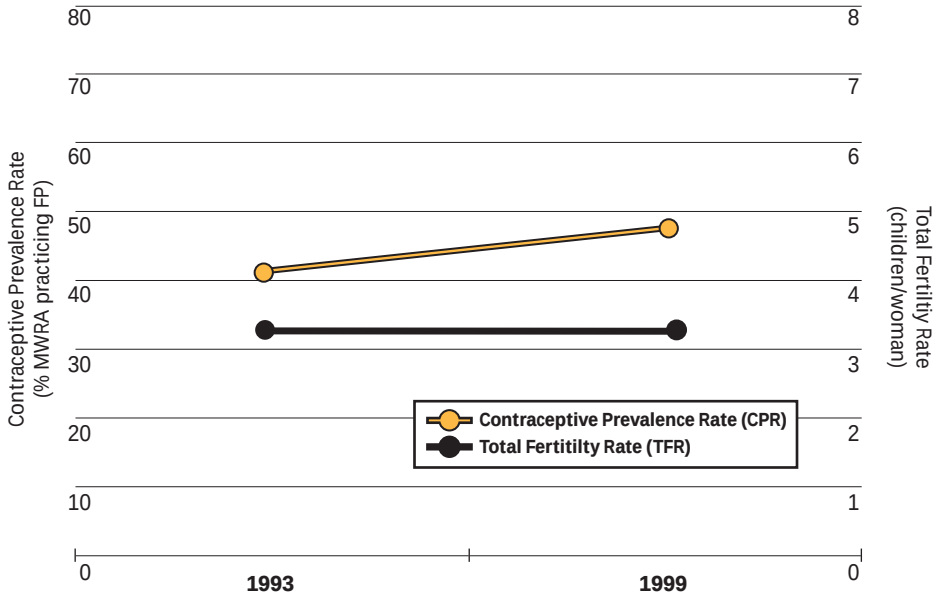
The policy identifies 14 national sociodemographic goals. They include providing free compulsory education up to 14 years of age; reducing infant mortality rate to below 30 per 1,000 live births; ensuring universal immunization; achieving 80 percent institutional birth deliveries; providing access to health information; containing the spread of AIDS; preventing and controlling other communicable diseases; promoting small family norms; and conducting a people-centered family welfare program.

Other Donors

Apart from USAID, the World Bank is the only other donor working in reproductive health in Uttar Pradesh. The Bank-supported Reproductive Child Health Program focuses on different districts than the IFPS activity. Both USAID and the Bank provide support for contraceptive logistics statewide. Whereas USAID supports training and quality improvement in logistics management and information systems, the Bank supports the cost of infrastructure.

Comments on this family planning/reproductive health country brief were not received from the Mission or Country Coordinator.

Contraceptive Prevalence and Total Fertility, 1993-1999



	1993	1999
CPR (% MWRA)	41	48
TFR (child/woman)	3.4	3.3
Infant Mortality Rate (deaths/1,000 live births)	78.5	68

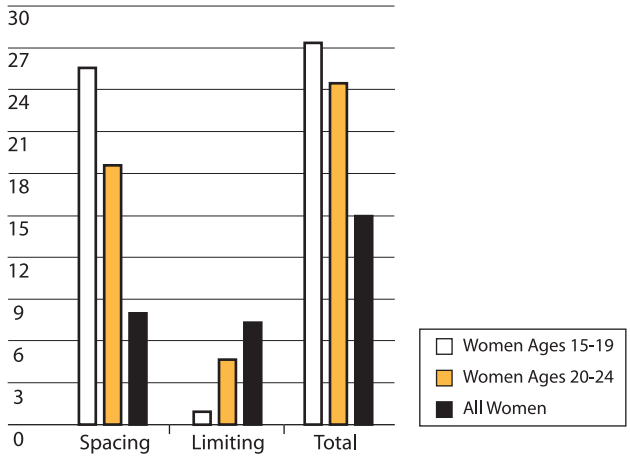
% Currently Married Women Using Family Planning by Method, 1993-1999

	1993	1999
Any Method	41	48
Traditional	4	5
Modern	37	43
Method Mix		
Sterilization	(F) 27.3 (M) 3.4	(F) 34 (M) 2
Pill	1.2	2
Condom	2.4	3
IUD	1.9	1.6

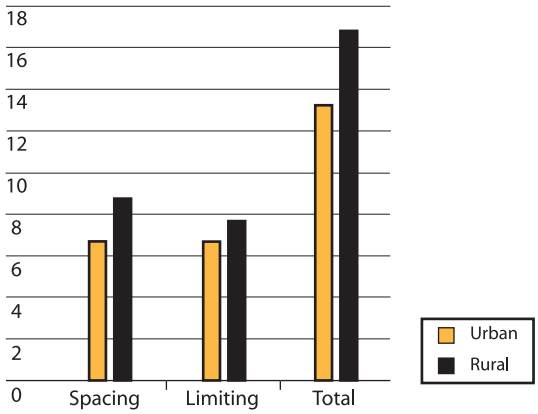
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

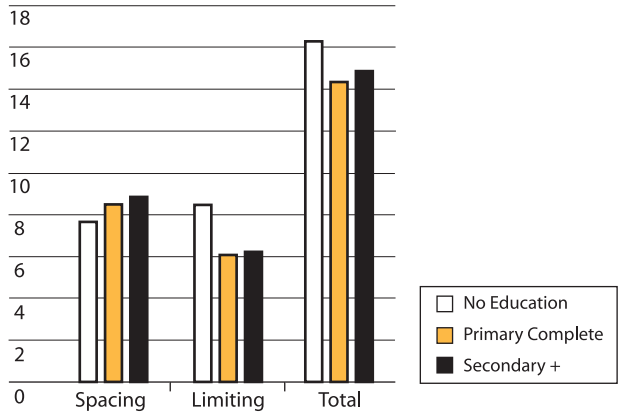
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Nepal

Country Brief

USAID has provided development assistance to Nepal since 1951 and is the lead donor for both the national family planning program and private-sector family planning activities. USAID's support for family planning in Nepal aims to increase use of contraceptives through expanding access to quality services. While there is a high level of awareness of family planning in Nepal, the key challenge is a large unmet demand for services.

Indicators

Population	23.5 Million
Urban	11%
Crude Birth Rate	35 per 1,000
Crude Death Rate	11 per 1,000
Annual Growth Rate	2.3%
Adult Literacy Rate	Male: 41% Female: 14%
Government Agency for Population Policy	Ministry of Population and Environment
Maternal Mortality Ratio	826 deaths per 100,000 live births
Births Attended by Trained Health Personnel	9%
DHS Years	1987,1996, 2001
Source of Family Planning Supplies	Public programs: 79% Private sector: 21%
Most Common Family Planning Method	Female sterilization

Background

Nepal's per capita income of $210 makes it the seventh poorest country in the world. Almost half its citizens live in absolute poverty. A limited natural resource base, rapid population growth, environmental degradation, low levels of social development, and widespread poverty present formidable development challenges.

Agriculture accounts for more than 40 percent of Nepal's gross domestic product and employs approximately 80 percent of the population. Only 30 percent of the land is arable. At its current growth rate of 2.3 percent, the population of 23 million will double in 29 years, and this growth will place enormous burdens on the environment, the economy, and health care and other services.

Since becoming a democracy in 1991, Nepal has made important advances in economic liberalization and in strengthening democratic governance at national and local levels. Elections have been free and fair, and transitions between governments have been peaceful. Nepal has formulated a sustainable market-driven agricultural growth strategy and has also made substantial progress in responding to the high demand for family planning services. Continued progress on these fronts is necessary to alleviate poverty and maintain popular support for the new democracy.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 2, *Reduced Fertility and Protected Health of Nepalese Families,* is supported by the following intermediate results (IRs):

IR 2.1: Increased use of quality family planning services

IR 2.2: Increased use of selected maternal and child health services

IR 2.3: Increased HIV/STD prevention and control practices by high-risk groups in targeted areas

IR 2.4: Strengthened capacity and programs to control selected infectious diseases

The major purposes of the USAID/Nepal health program are to reduce fertility and improve maternal and child health. These objectives are being met, but the needs in Nepal are vast – maternal mortality (826 maternal deaths per 100,000 live births) is among the highest in the Asia/Near East region, population growth is 2.3 percent, and under-five mortality is an estimated 92 deaths per 1,000 live births. Program objectives are met by expanding the use of quality voluntary family planning services; improving selected maternal and child health services; increasing HIV/STD prevention and control practices among high-risk groups; and strengthening institutional capacity and control of selected infectious diseases with a focus on vector-borne diseases and antimicrobial resistance.

USAID-supported programs deliver services nationwide through government agencies and units, local and international nongovernmental organizations (NGOs), contractors, and the private sector. A network of U.S.-based and local NGOs provides integrated family planning and community-based health services in 23 districts. The potential beneficiaries of the family planning/reproductive health program include the entire reproductive-age population, more than 11 million people. Child health services will reach about 90 percent of children under age 5 (about 3.5 million children). A maternal/neonatal health program initiated in 2000 is improving the policy environment and program coordination through a multidonor national Safe Motherhood subcommittee chaired by the government and a Safe Motherhood newsletter that provides a forum for information sharing and policy advocacy. The program has also developed a hospital-based district-level training package for delivering obstetric first aid to women in remote communities, and a birth-preparedness package to help women, families, and communities plan and prepare for pregnancy is under development. Through a program to better inform consumers of health and family planning services, over 10,000 women have completed health education and adult literacy classes.

Community health workers also provide information and services to promote family planning, child spacing, and safe birthing practices as well as to control diarrheal diseases, pneumonia, vitamin A deficiency, and HIV/AIDS.

USAID is the lead donor for both the national family planning program and private-sector family planning activities. Contraceptive distribution through private pharmacies has increased 84 percent under a USAID program to train pharmacists to dispense Depo-Provera. Since 1996, USAID has provided more than $2.5 million to support the development of a nationwide Logistics Management Information System (LMIS) to keep track of contraceptive stocks throughout the country. In 2000, the LMIS forecast that a national shortfall of contraceptives would occur beginning in 2001, and USAID, other donors, and the Nepal government (for the first time committing its own resources to contraceptive procurement) responded to avert the shortfall. With the improvements in contraceptive supply brought about by the LMIS, 84 percent of district warehouses now stock a three-month supply of essential contraceptives. For the future, USAID is helping the government develop an action plan for contraceptive security to promote long-term sustainability of the country's contraceptive supply.

To ensure high-quality family planning services, USAID continues support for the efforts of the Ministry of Health's Quality of Care Management Center to monitor and improve clinical services, with a focus on appropriate counseling and informed consent. USAID also supports two innovative national radio programs that are increasing family planning provider knowledge and educating the public on the importance of family planning and other health information.

USAID works with a wide network of contractors, grantees, and other agencies. Its principal partners in family planning/reproductive health are Family Health International (FHI); the Center for Development and Population Activities (CEDPA); EngenderHealth; Johns Hopkins University; John Snow, Inc./Family Planning Logistics Management (FPLM); and the U.S. Centers for Disease Control and Prevention (CDC).

National Health Policy and Plans

The Family Planning Association of Nepal (FPAN) was established in 1959 to create awareness about the need and importance of family planning. It did not offer any family planning services until 1975, however. Initially, these services were limited to the Kathmandu valley. The work of FPAN led to the establishment at the governmental level of the semiautonomous Nepal Family Planning and Maternal Child Health Project in 1968. This project gradually covered all 75 districts of Nepal.

Government-run family planning services have since remained an integral part of health services. Health services in Nepal are delivered through national, regional, zonal, and district hospitals, primary health care centers, health posts, and subhealth posts, all of which provide condoms, oral contraceptives, and injectable contraception on a regular basis. Peripheral health workers and volunteers also provide these methods. Services such as Norplant implants and IUD insertions are only available at a limited number of hospitals, health centers, and selected health posts where trained providers are available. Depending on the district, sterilization services are provided at static sites (21 districts), through scheduled seasonal services, or via mobile outreach services.

In 1995, the Ministry of Population and Environment was established as a separate ministry for population-related activities, a sign of the government's strong commitment to population programs. This ministry is primarily responsible for formulating and implementing population policies, plans, and programs, and for monitoring and evaluating these programs. Along with the Ministry of Health, it is responsible for implementing programs of action recommended by the 1994 Cairo conference on population and development.

The Ministry of Health remains responsible for reproductive health-related population activities such as fam-

ily planning, safe motherhood, adolescent reproductive health, STD, and infertility programs. At the central level, the Family Health Division in the Department of Health Services is responsible for planning, supervising, and implementing family planning activities. National and regional training centers are responsible for training field workers for reproductive health services. The National Heath Education, Information, and Communication Centers of the Department of Health Services conduct information and education activities in reproductive health.

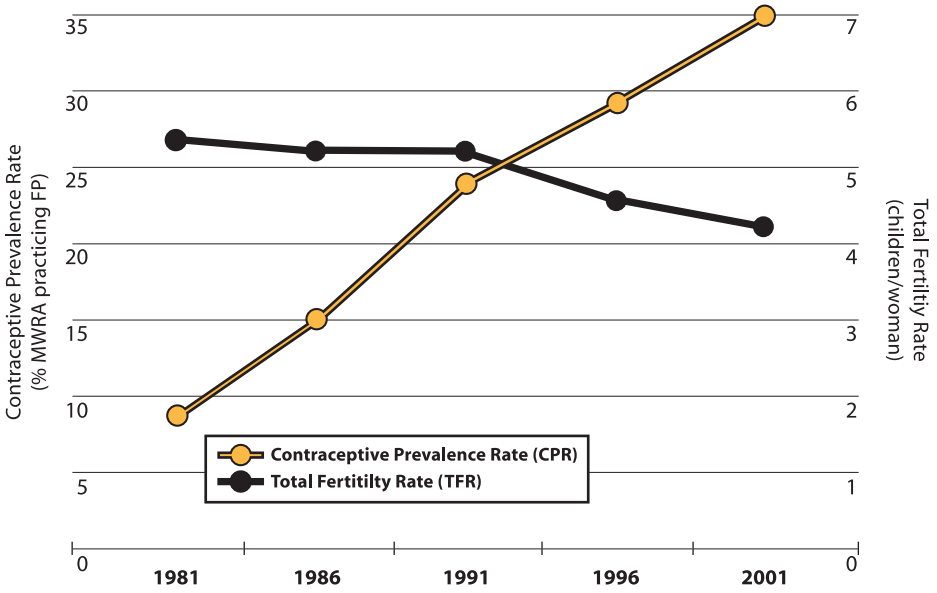
Other Donors

USAID actively collaborates in the health sector with other donors, including United Nations Development Programme, UNFPA, UNICEF, WHO, the Australian Agency for International Development, the U.K. Department for International Development (DFID), the Japan International Cooperation Agency (JICA), the German technical cooperation agency GTZ, and the German development bank KfW. UNFPA and USAID work together very closely in the family planning program, with UNFPA taking a greater role in Ministry of Health data management and contraceptive procurement. KfW is cofunding the Commercial Retail Sales project for the social marketing of condoms, contraceptives, and oral rehydration salts. There has been increasing cooperation with WHO for cofunding workshops and collaborating on other activities in the infectious diseases program. JICA is also interested in future collaboration on this program.

Comments on this family planning/reproductive health country brief were received from the Country Coordinator on 10/30/01.

Indicators and Trends

Contraceptive Prevalence and Total Fertility, 1981-2001



	1981	1986	1991	1996	2001
CPR (% MWRA)	8	15	24	29*	35
TFR (child/woman)	5.3	5.1	5.1	4.6	4.1
Infant Mortality Rate (deaths/1,000 live births)		103	80	79	

* 1996 DHS did not include pregnant women when calculating contraceptive prevalence, which is thus higher than would be obtained using standard method of calculation.

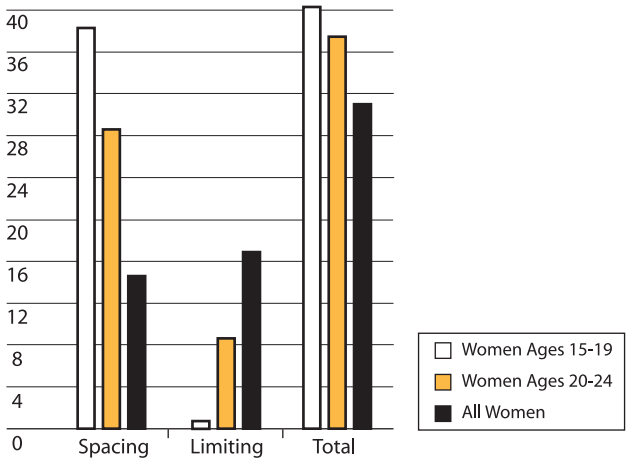
% Currently Married Women Using Family Planning by Method, 1987-2001

	1987	1996	2001
Any Method		28.5	35 (no breakdown)
Traditional		2.5	
Modern	15.7	26.0	
Method Mix			
Sterilization	(F) 6.8 (M) 6.2	(F) 12.1 (M) 5.4	
Oral contraceptives	0.9	1.4	
Condom	0.6	1.9	
Injectables	0.5	4.5	
Implants	N/A	0.4	
IUD	0.1	0.3	

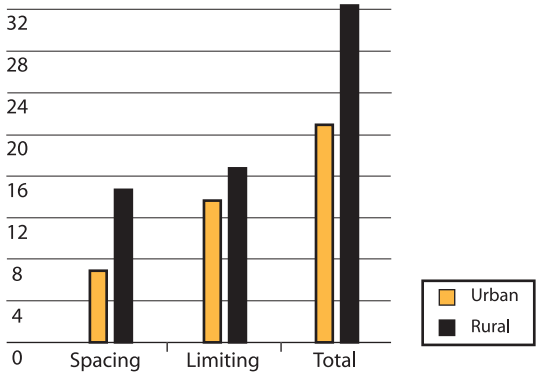
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

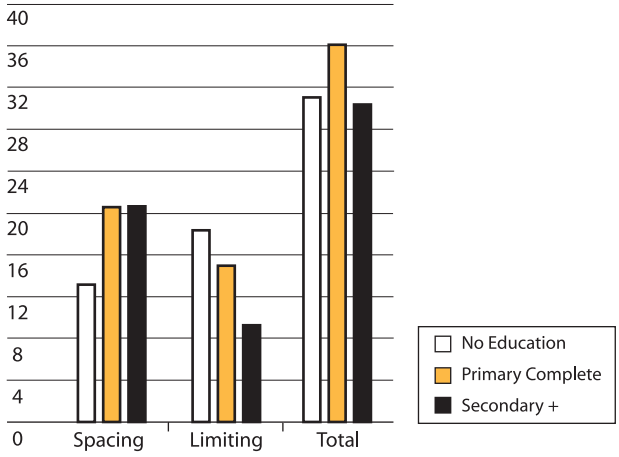
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.

Annual growth rate: U.S. Bureau of the Census, International Database, 2000.

Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

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Pakistan

Country Brief

Between 1948 and 1990, USAID and its predecessor agencies provided Pakistan with $7.9 billion in assistance. Pakistan became a USAID "nonpresence" country after bilateral assistance ceased in 1995, but USAID continues to fund social sector activities by nongovernmental organizations in family planning and reproductive health. Despite being one of the first developing countries to establish a family planning program, Pakistan has achieved little progress in increasing contraceptive use and reducing fertility. Challenges have included social and cultural constraints and inconsistent political and financial support.

Indicators

Population	145 Million
Urban	33%
Crude Birth Rate	39 per 1,000
Crude Death Rate	11 per 1,000
Annual Growth Rate	2.2%
Adult Literacy Rate	Male: 50% Female: 24%
Government Agency for Population Policy	Ministry of Population Welfare and the Ministry of Planning
Maternal Mortality Ratio	201 per 100,000 live births
Births Attended by Trained Health Personnel	19%
DHS Years	1991
Source of Family Planning Supplies	Public programs: 53% Private sector: 45%
Most Common Family Planning Method	Female sterilization

Background

Starting in the 1950s, Pakistan was one of the first developing countries with a large population to support and implement family planning activities. Subsequent five-year national development plans have noted rapid population growth and included provisions to support a family planning program to address the issue. These development plans have adopted different approaches and strategies, in terms of program design, coverage, outreach, supervision, and guidance, to promote the concept of a small family norm and encourage the use of modern family planning methods. Due to inconsistent governmental commitment and social and cultural constraints, however, the program has not effectively provided or generated widespread demand for family planning services. After several decades of operation, the program has had little effect in inhibiting fertility, and contraceptive use remains low. Financial and operational obstacles have also hindered the program, which reaches only 25 to 30 percent of the population, with family planning facilities more concentrated in urban than rural areas.

USAID Health Program and Strategies

USAID and its predecessor agencies provided Pakistan with $7.9 billion in assistance from 1948 to 1990. In 1990, the USAID Mission for Pakistan (and Afghanistan) began an orderly, phased close-out after the Pressler amendment on nuclear nonproliferation mandated the termination of economic and military assistance to the country. The USAID bilateral development program closed on May 28, 1995, and Pakistan is now a USAID "nonpresence" country.

Although the Pressler amendment required termination of bilateral USAID assistance, the subsequent Harkin, Glenn-Symington, and Brown amendments, as well as "notwithstanding" legislation, opened some avenues for USAID assistance. These avenues have included the Trade and Development Agency (TDA), the Overseas Private Investment Corporation (OPIC), the Export-Import Bank (EX-IM), the Global Learning and Observation to Benefit the Environment (GLOBE) program, assistance under public law 480 (PL-480), and especially assistance to nongovernmental organization (NGO) programs.

Pakistan's nuclear testing in May 1998 necessitated a review of all U.S. assistance. In general, PL-480 and NGO humanitarian assistance to Pakistan were allowed to continue. TDA, OPIC and EX-IM assistance programs were temporarily suspended but have since been restored.

In September 1994, while attending the United Nations International Conference on Population and Development in Cairo, Vice President Gore advised Pakistan's Prime Minister Bhutto that the United States would fund social sector assistance activities in Pakistan implemented by NGOs. During her November 1997 visit to Pakistan, Secretary of State Albright renewed and extended this commitment.

The resulting Pakistan NGO Initiative (PNI), authorized April 10, 1995, is a $19 million, six-year USAID program implemented through grants to the Asia Foundation and the Aga Khan Foundation. It is separate from but complementary to the Government of Pakistan's national Social Action Plan (SAP), which is funded by the World Bank.

PNI's purpose is to strengthen NGO capacity to work with local community-based organizations to improve basic education, literacy and skills development, reproductive health (including family planning), mother and child health, and income-generation opportunities. PNI's primary focus is on community participation and, most importantly, the empowerment of women and girls. PNI supports USAID's strategic objectives in maternal/child health, child survival, and basic education.

PNI operates independently of the Pakistani government and is coordinated with major donors, whose programs are focused on Pakistan's priority needs as defined in the World Bank-supported SAP. The SAP encourages NGO and private sector participation in the

delivery of social services. PNI thus complements other donor programs and national priorities.

Despite years and millions of dollars of assistance from USAID and others, population growth, family planning, and basic education remain paramount concerns in Pakistan. With 145 million people, Pakistan is already the world's seventh most populous country; it will rank fifth in 2020, when its population is projected to reach 262 million, and third in the world, behind China and India, in 2050.

National Health Policy and Plans

The Ministry of Health provides health care services through government hospitals and other health care outlets. The objective of the health policy is to reduce the incidence of morbidity and mortality by providing preventive and curative care to the whole population. Reducing infant and child mortality, curtailing severe undernutrition among children and mothers, and improving child survival and safe motherhood receive specific attention.

To combat high childhood morbidity and mortality from infectious and communicable diseases, an immunization program was initiated in 1978. The program, which was greatly accelerated in 1982 with WHO and UNICEF collaboration, protects infants and young children against six common diseases and pregnant mothers against tetanus. The WHO Expanded Program on Immunization is a major component of this effort to provide universal immunization.

High maternal mortality is a health policy priority. Mothers receive antenatal and postnatal services at maternal and child health centers. These services are complemented by projects focusing on child survival and nutrition through growth monitoring, adequate food supplementation, and breastfeeding promotion.

The government is committed to improving the quality of health services and the coverage of primary health care services, especially in rural areas. Provincial health departments provide these services through "basic health units" and rural health centers.

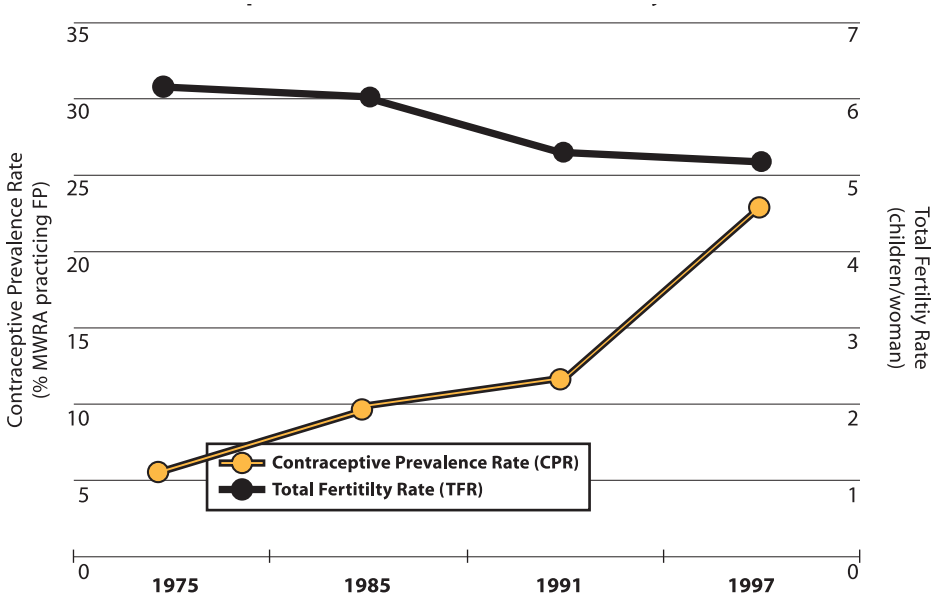
Other Donors

All donor programs are focused on Pakistan's needs as defined in the World Bank-supported SAP. The main donors are the Asian Development Bank, WHO, UNICEF, the Canadian International Development Agency (CIDA), and the European Union.

Comments on this family planning/reproductive health country brief were not received from the Country Coordinator.

Indicators and Trends

Contraceptive Prevalence and Total Fertility, 1975-1997



	1975	1985	1991	1997
CPR (% MWRA)	5.5	9.1	11.9	23.9
TFR (child/woman)	6.3	6.0	5.4	5.3

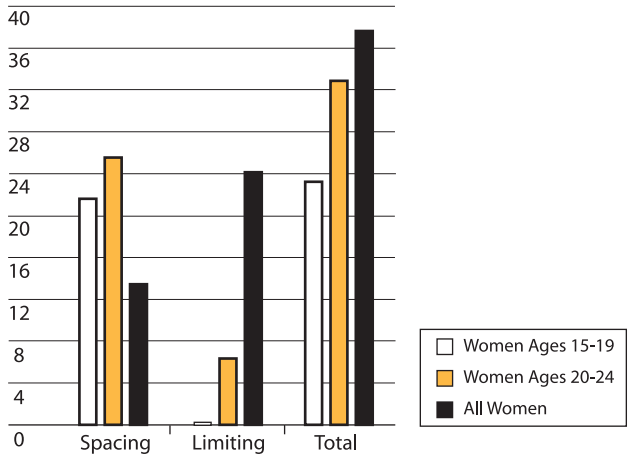
% Currently Married Women Using Family Planning by Method, 1991-1997

	1991(DHS)	**1997**(PFFPS)
Any Method	11.8	23.9
Traditional	2.8	7
Modern	9	16.9
Method Mix		
Sterilization	(F) 3.5 (M) 0	(F) 6.0 (M) 0
Pill	0.7	1.6
Condom	2.7	4.2
Injectables	0.8	1.4
IUD	1.3	3.4

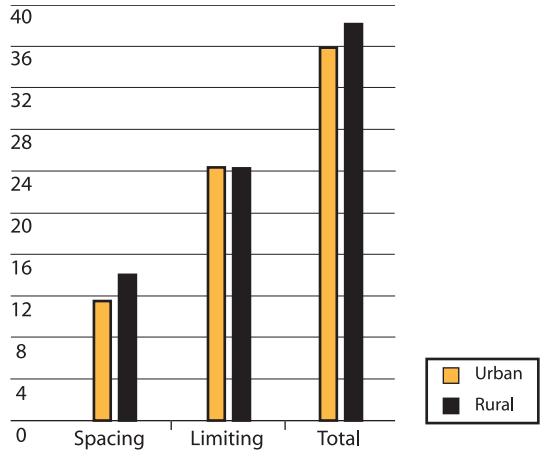
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

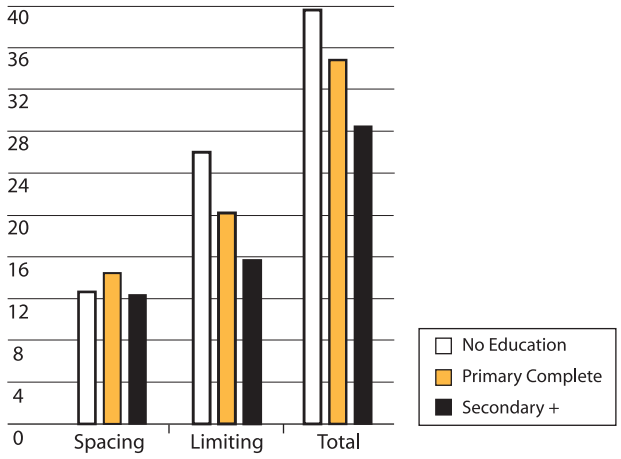
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

SOUTHEAST ASIA

Cambodia

Indonesia

Philippines

Vietnam

Cambodia

Country Brief

USAID began assistance to Cambodia in 1986. Since the 1997 prohibition on direct assistance to the government, USAID has been the eighth largest donor to Cambodia. USAID implements family planning and reproductive health activities through local nongovernmental organizations, with an emphasis on strengthening their capacity. National population policies in Cambodia affirm the right of all women to have access to contraception and emphasize birth spacing and safe motherhood. A critical challenge facing Cambodia is the explosive HIV/AIDS epidemic, which threatens to undermine the development of the health sector. To help meet that challenge, Cambodia is one of only four countries (and the only one outside Africa) to be designated an HIV/AIDS "rapid scale-up" country.

Indicators

Population	13.1 Million
Urban	16%
Crude Birth Rate	28 per 1,000
Crude Death Rate	11 per 1,000
Annual Growth Rate	2.3%
Adult Literacy Rate	Male: 81.8% Female: 58.0%
Government Agency for Population Policy	No responsible agency established
Maternal Mortality Ratio	590 per 100,000 live births
Births Attended by Trained Health Personnel	34%
DHS Years	2000
Source of Family Planning Supplies	N/A
Most Common Family Planning Method	Injectables

Background

USAID's program in Cambodia traces its roots to humanitarian assistance activities in support of noncommunist resistance groups. These activities began in 1986, and U.S. assistance accelerated sharply following the 1991 signing of the Paris Agreements on a Comprehensive Political Settlement of the Cambodia Conflict. The organizational embodiment of this agreement was the United Nations Transitional Authority in Cambodia (UNTAC), the most complex and expensive peacekeeping operation in United Nations history. UNTAC's prime mission was to create conditions for free, fair, and open national elections, and it substantially fulfilled this mission. The 1993 elections resulted in a fragile power-sharing agreement between the Cambodian People's Party (CPP), which had held power during the entire period of Vietnamese occupation in the 1980s, and the National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia (FUNCINPEC), the royalist party that won a plurality of votes. National reconciliation was incomplete, however, and the phased cantonment, disarming, and demobilization of the parties' military forces did not take place.

In July 1997, opposing forces of Second Prime Minister Hun Sen of the CPP and First Prime Minister Norodom Ranariddh of FUNCINPEC clashed violently while the latter was out of the country. The fighting resulted in Ranariddh's ouster from power. In response, the United States suspended about two-thirds of its $38 million Cambodian aid program. Only activities that help meet basic human needs (such as activities supporting maternal/child health, HIV/AIDS prevention, assistance to war and mine victims, and certain economic growth programs) or that strengthen the democratic process and respect for human rights were approved for continuation. Legislative and policy restrictions remain in effect, due in part to the controversial July 1998 elections and despite the formation of a coalition government in November 1998. The restrictions prohibiting direct assistance to the government have yet to be lifted.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 2, *Improved Reproductive and Child Health,* is supported by the following intermediate results (IRs):

IR 2.1: Expanded supply of reproductive and child health services

IR 2.2: Increased access to reproductive and child health services

IR 2.3: Strengthened demand for reproductive and child health services

Because of the prohibitions on direct assistance, USAID's strategy in the health sector has changed from working with the Ministry of Health to developing and strengthening the delivery of essential health care services through indigenous and international organizations. Nongovernmental organizations (NGOs) are increasingly stepping forward to deliver services and provide training, technical assistance, information exchange, and advocacy support. USAID's NGO partners have increased the proportion of women seeking antenatal care, provided high-quality care for obstetric complications in areas where none was available before, and doubled contraceptive prevalence in areas where family planning services have been made available. Using village development committees, the NGOs have penetrated rural areas with high-impact child survival programs, and they have trained 900 staff from 46 public health centers in case management of childhood illnesses. They have also promoted the micronutrient agenda through educational materials and the launching of a large-scale salt iodization program.

Southeast Asia's HIV/AIDS epidemic is particularly severe in Cambodia. Adult prevalence is estimated at 3.7 percent. The Cambodian government, the NGO community, and international donors all recognize the serious threat HIV poses to Cambodia's fragile national development. USAID/Cambodia began supporting HIV/AIDS-related activities in 1996. Late in 2000,

Cambodia was identified as one of four "rapid scale-up" countries under the Agency's expanded response to the global HIV pandemic.

USAID's major partners are EngenderHealth, CARE International, Helen Keller International, Partners for Development, the Reproductive Health Association of Cambodia, Population Services International, Family Health International/IMPACT, International HIV/AIDS Alliance/KHANA, and John Snow, Inc.

National Health Policy and Plans

According to Sonia Correa's *Implementing ICPD: Moving Forward in the Eye of the Storm,* Cambodia's progress in reproductive health services is a direct result of the 1994 Cairo International Conference on Population and Development (ICPD). New national population policies established after 1994 emphasize birth spacing and safe motherhood instead of exclusively focusing on fertility control. They also include statements on rights, and a progressive 1995 birth spacing policy affirms the access of all women to contraceptives as a right.

In 1998, a full-time minister was appointed to the Ministry of Women's and Veterans' Affairs. A five-year program called *Nearly Rattanak* ("Women are Precious Gems") was launched on March 8, 1999, to examine the status and rights of women nationwide and find ways to bring women into the decision-making process. The Ministry has established strategies to include gender as a mainstream issue to be addressed in four areas – education, reproductive health, economic empowerment, and legal protection. The Ministry has also established mechanisms for monitoring the implementation of these strategies nationwide. These mechanisms include clear indicators and check boards to measure the improvement of the status of women and girls in the four areas.

Other Donors

Total development assistance to Cambodia has returned to the pre-July 1997 level of about $450 million annually. Before the 1997 aid suspension, the United States was the second largest bilateral donor after Japan, but is now the eighth largest, behind Japan, the World Bank, the Asian Development Bank, the European Union, the United Nations Development Programme, Australia, and Germany. The United States is the only donor not to have resumed bilateral aid, and its level of assistance is only slightly above Sweden's and the United Kingdom's. Most of the assistance from other donors is directed at infrastructure projects, rural development, poverty alleviation, and social sector spending.

Comments on this family planning/reproductive health country brief were received from the Mission on 1/29/02.

% Currently Married Women Using Family Planning by Method, 2000

	2000
Any Method	23.8
Traditional	5.3
Modern	18.5
Method Mix	
Sterilization	(F) 1.5 (M) 0.2
Pill	4.5
Monthly pill	2.7
Condom	0.9
Injectables	7.4
Implants	0.1
IUD	1.3

Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Indonesia

Country Brief

USAID began providing development assistance to Indonesia in 1950 and remains one of the leading bilateral health donors. Since the late 1970s, Indonesia has made great progress in reducing population growth and child mortality, due in part to strong political commitment. USAID's family planning program in Indonesia currently focuses on improving the quality and sustainability of services in six provinces that hold more than 70 percent of the national population. Challenges include continuing political and economic crises that jeopardize Indonesia's long record of progress in improving health services.

Indicators

Population	206.1Million
Urban	39%
Crude Birth Rate	23 per 1,000
Crude Death Rate	6 per 1,000
Annual Growth Rate	1.7%
Adult Literacy Rate	Male: 90% Female: 78%
Government Agency for Population Policy	National Family Planning Coordinating Board
Maternal Mortality Ratio	472 per 100,000 live births
Births Attended by Trained Health Personnel	43%
DHS Years	1987,1991,1994,1997
Source of Family Planning Supplies	Public programs: 43% Private sector: 57%
Most Common Family Planning Method	Injectables

Background

Spanning the trade routes between the Pacific and Indian oceans, Indonesia is a key player in Asia's economic recovery and a major supplier of natural resources. With the world's fourth largest (and largest Islamic) population, it is an important emerging market for U.S. trade and investment but is now beset by political uncertainty. The country is in the midst of a turbulent transition from autocracy to democracy, from a captive economy to free markets, from a command state to civil society. While remarkable progress has already occurred as part of these changes, it has often been obscured by eruptions of violence, struggles for power, and political and economic reversals. Nonetheless, the impetus for reform continues to gather strength. If it succeeds, it will reshape the pattern of relations across the archipelago and transform the very character of Indonesia's governance, economy, and international relations.

Indonesia's multiple transitions require constructing new political and economic systems and reconstructing social relationships to ensure greater equity across regions and between classes. A democratically elected government (the first in 45 years) is in power and pursuing a reform agenda. People are asserting their rights. Concerns over corruption and judicial performance are receiving heightened attention. Political and fiscal power is being decentralized and dispersed to subnational units of government and to districts and cities (although poor management of this process threatens a decline in access to and quality of services). These developments have been accompanied by dangerous and potentially contagious sectarian and political violence that has displaced large numbers of people and threatens the country's fragile social balance.

After a protracted economic crisis (made worse by the worst drought in 50 years), the economy has stabilized and is showing modest signs of improvement. The crisis, however, forced many people into near poverty. The sharp decline in living standards has made many groups more susceptible to political appeals based on religious and sectarian sentiments, and a rise in food prices and shortages of rice, cooking oil, and sugar were contributing factors in the May 1998 riots. Natural resources and the environment are under relentless pressure.

The economic crisis also cut access to social services and caused a decline in social welfare. Lowered incomes have made health services unaffordable, and budget constraints have reduced the government's ability to provide services. Families now delay health care, increasing morbidity and mortality. Increased poverty has significantly worsened the nutritional status and the health of vulnerable groups, particularly women and children. The economic crisis and spread of sectarian conflict have also increased threats to women's security, political status, and basic rights.

The effects of the economic crisis and political turmoil have included increases in malnutrition, the severity of illness among pregnant women and young children, and use of traditional health practitioners. Sexually transmitted diseases are on the rise, as a result of inadequate condom use, delayed treatment, and an increase in prostitution to supplement reduced incomes. HIV/AIDS has gained a foothold in Indonesia and has the potential to spread rapidly due to migration patterns and the growing numbers of women and men engaging in commercial sex.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 8, Health of Women and Children Improved, is supported by the following intermediate results (IRs):

IR 8.1: Policy environment for reproductive and child health improved

IR 8.2: Health service systems strengthened to improve access, quality, and sustainability

IR 8.3: Women, families, and communities empowered to take responsibility for improving health

The SO's goal is to protect the health of the most vulnerable women and children by ensuring access to and availability of comprehensive reproductive and child health services and information. Particular emphasis is placed on strengthening surveillance systems to respond to the needs of the urban and rural poor, internally displaced persons, and populations at risk for HIV/AIDS.

The health objective and strategy builds on existing efforts to respond to the economic and political crises. For the past two years, the program was concerned with establishing surveillance systems to monitor the effects of the crisis on nutrition and health and with preserving the delivery of essential preventive health services to the most vulnerable women and children. USAID also provided development assistance funds to improve the availability and use of family planning in 11 provinces covering an estimated 75 percent of the population. Child Survival and Disease funds have targeted maternal and neonatal health services at the village level, where only one in two pregnant women uses a trained midwife for her delivery. They have also supported activities to prevent micronutrient deficiencies and improve child nutrition in five provinces and services to prevent the transmission of HIV/AIDS and other STIs in three major urban areas.

As Indonesia recovers from the economic crisis and as democratization takes root, USAID's health strategy will evolve into a three-pronged approach that supports the supply and demand aspects of health within the context of decentralization. The approach will:

- Improve the enabling environment in accordance with health reforms already underway
- Strengthen the capacity and commitment of the Indonesian government and the private sector, particularly at the district level, to meet the needs of the people
- Help individuals and communities participate more fully in building a healthy Indonesia by deciding what quality health care means to them, by learning to demand these services from locally elected representatives, and by improving their own behaviors

USAID will focus its family planning efforts on Jakarta, the three Javanese provinces, and North Sumatra, South Sumatra, and Lampung provinces. Together, these provinces contain 150 million people (more than 70 percent of the total population) and high levels of unmet need. Maternal and child health efforts will focus on West Java province, with 42 million people (20 percent of the total), and selected districts in East and Central Java. A new program to reestablish and maintain a decentralized preventive health outreach system among displaced families returning home will be initiated in Aceh province. HIV/AIDS efforts will concentrate on 10 urban centers throughout the country, with special emphasis on Papua, where HIV/AIDS is spreading most rapidly. An initiative to improve the health and well-being of street children will be implemented in four major urban areas.

USAID's major partners are Pathfinder International and the Futures Group International (family planning); Johns Hopkins University/Population Communication Services (information, education, and communication materials for family planning and overall health promotion); Helen Keller International (nutrition and disease surveillance, vitamin A promotion, and maternal micronutrient supplementation); World Vision (emergency health services among internally displaced persons in two provinces and infant feeding programs in major urban centers); and Family Health International/Program for Appropriate Technology in Health (PATH) (promoting HIV/AIDS prevention in Irian Jaya).

National Health Policy and Plans

For more than 30 years, Indonesia has devoted many of its development programs to population-related issues. In 1967, President Suharto joined other heads of state in signing the Declaration of the World Leaders, which recognized rapid population growth as an obstacle to eco-

nomic development. Since the late 1970s, the country has achieved tremendous progress in reducing population growth and child mortality. This progress was in large part due to strong, centralized political commitment to reducing fertility and under-five child mortality. Another contributing factor to Indonesia's success has been community involvement in applying the principle that family planning is more than simply controlling births. The 1992 Legislative Act No. 10 explicitly defined family planning as society's effort to create small, happy, and prosperous families through increasing concern and support for delayed marriage, controlled births, and improved family resilience and welfare.

In order to carry out its population policy, the government has launched several programs that included family planning as an important component. In less than three decades, the policy has contributed to reducing the fertility rate of the country by half and helped improve family welfare. Nonetheless, the population is still growing at a rate of 1.7 percent per year, and maternal and neonatal mortality rates remain among the highest in the region.

A healthy population is a critical prerequisite for building a democratic and prosperous Indonesia. Studies suggest that infant mortality, a good indicator of the overall quality of life, correlates strongly with political instability and slow socioeconomic development. At present, Indonesia's political and economic crises are concerns that threaten to undermine (if they have not already) the country's long record of progress in improving health. Under the new decentralization laws, 249 regencies and 65 municipalities will receive new responsibilities for planning, financing, and managing health and family planning programs. It remains to be seen, however, if the government can continue to ensure that the health needs of the growing population are met while it meets the imperatives of decentralization and other political changes.

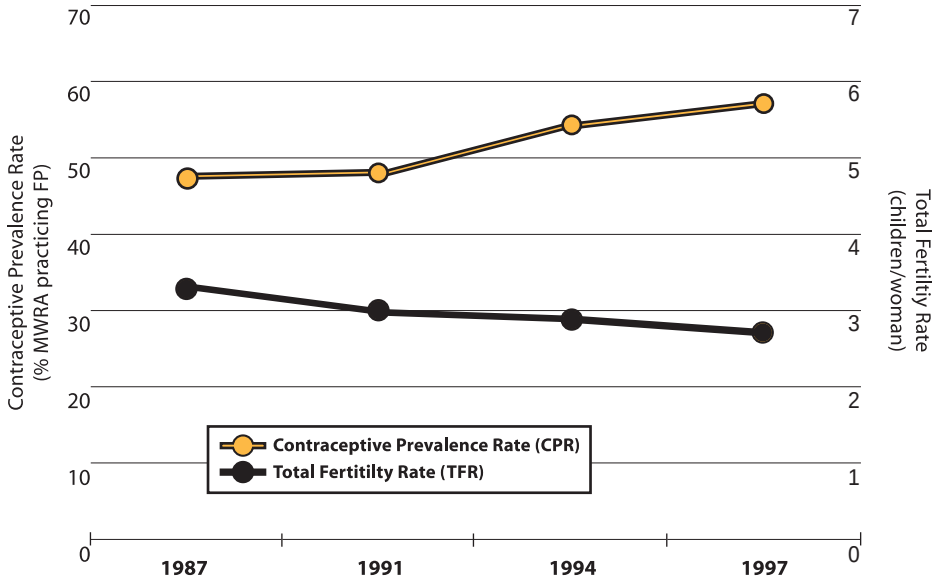
Other Donors

USAID/Indonesia is one of the leading bilateral health donors and has a close working relationship with all of the major donors. USAID is a member of the Partners in Health Working Group, a high-level advisory group to the Minister of Health led by the World Bank, UNICEF, the Asian Development Bank (ADB), and WHO. The World Bank and ADB have significant investments in the "Social Safety Net" program, to which they apply health tools and approaches developed by USAID. WHO is supporting reproductive health policy and the national application of the Integrated Management of Childhood Illness (IMCI) protocol for child health case management, which is an effective complement to USAID's work at the district and provincial levels. USAID is contributing to UNICEF/government infant feeding programs at the community level and to a UNICEF/government program on iodine deficiency. UNICEF is also supporting immunization, water and sanitation, and child rights. UNFPA focuses on adolescent and reproductive health and also addresses gender equity and violence against women. The Australian Agency for International Development is the only other bilateral donor working on HIV/AIDS, and it also has a comprehensive women's health and family welfare program in the eastern islands. The Japanese International Cooperation Agency is supporting an effort in South Sulawesi to improve service delivery and health administration. Other major donors and foundations in the health sector include the Gates Foundation, the Turner Foundation, the European Union, UNAIDS, and the German development bank KfW.

Comments on this family planning/reproductive health country brief were not received from the Mission or Country Coordinator.

Indicators and Trends

Contraceptive Prevalence and Total Fertility, 1987-1997



	1987	1991	1994	1997
CPR (% MWRA)	47.7	49.7	54.7	57.4
TFR (child/woman)	3.4	3.0	2.9	2.8
Infant Mortality Rate (deaths/1,000 live births)		68	57	46

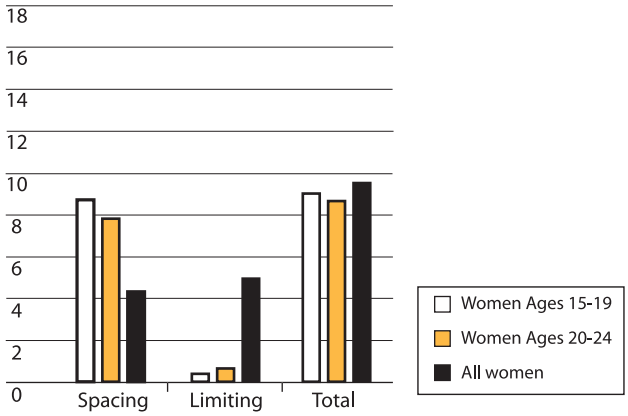
% Currently Married Women Using Family Planning by Method, 1991-1997

	1991	1997
Any Method	49.7	57.4
Traditional	2.6	2.7
Modern	47.1	54.7
Method Mix		
Sterilization	(F) 2.7 (M) 0.6	(F) 3.0 (M) 0.4
Pill	14.8	15.4
Condom	0.8	0.7
Injectables	11.7	21.1
Implants	3.1	6.0
IUD	13.3	8.1

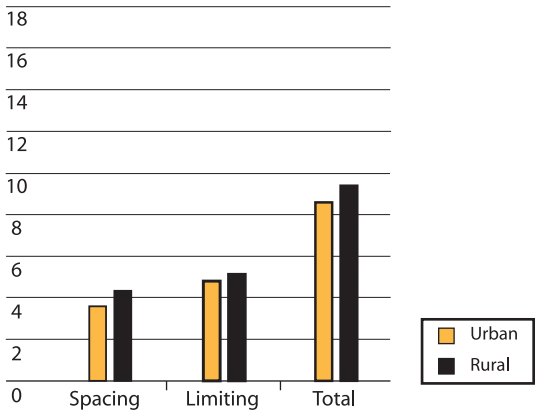
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

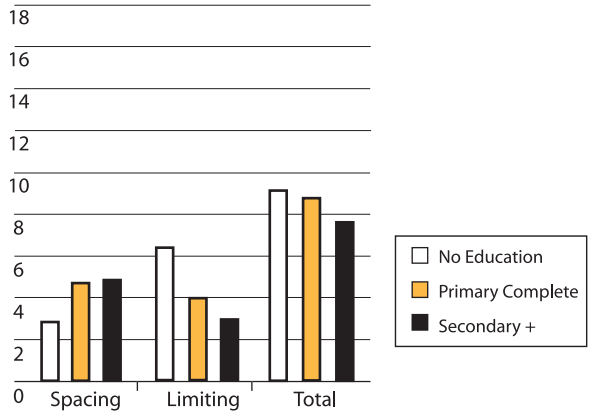
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Philippines

Country Brief

The United States has provided assistance to the Philippines since 1946. USAID is the largest donor to the Philippines national family planning program and as of 2000 had provided $143 million in assistance in the population and health sector. Current family planning activities focus on private sector promotion and strengthening the government's capacity to deliver family planning services. Challenges facing family planning efforts in the Philippines include the Roman Catholic Church's opposition to modern contraceptive methods.

Indicators

Population	77.2 Million
Urban	47%
Crude Birth Rate	29 per 1,000
Crude Death Rate	6 per 1,000
Annual Growth Rate	2.1%
Adult Literacy Rate	Male: 95% Female: 94%
Government Agency for Population Policy	Commission on Population
Maternal Mortality Ratio	238 per 100,000 live births
Births Attended by Trained Health Personnel	56%
DHS Years	1993,1998
Source of Family Planning Supplies	Public programs: 72% Private sector: 28%
Most Common Family Planning Method	Traditional

Background

The Philippines has come through the Asian financial crisis and a severe drought with limited adverse effects. The country is growing again, although deeply ingrained obstacles to sustainable growth remain. The persistence and severity of these obstacles is highlighted by the country's slow growth compared with its Asian neighbors. Over the past 30 years, the country's economic growth has lagged well behind not only the "Asian tigers" but behind the less advanced economies of the region as well.

Although the Philippines has lagged economically, its democratic systems have demonstrated vibrancy and resilience. USAID intends to pursue a more focused strategy to promote competition and transparency, combat corruption and cronyism, enhance donor coordination and collaboration, encourage environmentally sustainable development, and employ market-based mechanisms to promote family planning and reforms in health services delivery.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 3, Reduced Fertility Rate and Improved Maternal and Child Health, is supported by the following intermediate results (IRs):

IR 3.1: Increased public sector provision of family planning/maternal and child health (FP/MCH) services

IR 3.2: National system strengthened to promote and support the FP/MCH program

IR 3.3: Increased private sector provisions of contraceptives and FP/MCH services

The Mission merged a Special Objective, Threat of HIV/AIDS and Other Selected Infectious Diseases Reduced, with SO 3 in 2001. It is supported by the following IR: Knowledge, attitudes, and practices for STD/HIV/AIDS prevention by high-risk groups increased.

The purposes of the health strategic objectives are to reduce the fertility rate, improve maternal and child health, and prevent the rapid increase of HIV/AIDS and other infectious diseases. The approach is to work with both the private and public sectors while building the government's capacity to better provide health care services.

In the private sector program, USAID has helped establish the FriendlyCare Foundation, Inc., a new private foundation to accelerate provision of paid quality primary health care and family planning services to lower-middle income groups. USAID is also assisting more than 190 midwife clinics that provide FP/MCH services.

The public sector program is assisting the government's Contraceptive Interdependence Initiative to increase funding of contraceptives and is working with the Department of Health (DOH) toward self-reliance in family planning service delivery. USAID is also helping local government units provide quality FP/MCH services in public health facilities targeted at the poor.

USAID assists the DOH's Health Sector Reform Agenda through technical assistance to improve the national health insurance program, provide fiscal and management autonomy to government hospitals, reestablish the district health system, and improve the procurement and distribution of essential drugs and supplies, including contraceptives.

USAID supports HIV/AIDS surveillance and education activities in high-risk behavior in eight major cities. The objective is to keep the HIV infection rate in the general population below 3 percent.

The Philippines has the highest tuberculosis incidence in Asia and the third highest in the world. USAID's approach focuses on controlling tuberculosis (and malaria and dengue fever) by strengthening surveillance and control capacity at all levels of the health system and the control capacity of local government units.

USAID implements activities through the DOH, the Commission on Population (POPCOM), local govern-

ments, and nongovernmental organizations (NGOs). Major contractors include Management Sciences for Health, the Futures Group International, Johns Hopkins University, the Population Council, EngenderHealth, Macro International, Deloitte Touche Tohmatsu, the U.S. Bureau of the Census, and John Snow, Inc.

National Health Policy and Plans

Before the 1994 Cairo International Conference on Population and Development (ICPD), POPCOM and the DOH were already defining their respective women-oriented programs on population and family planning. After ICPD and the 1995 Fourth World Conference on Women, the DOH adopted a new Philippine Family Planning Program with three components: an integrated family planning/maternal health program; a women's health/safe motherhood project; and strengthened management and field implementation, with a three-track orientation in women's health care.

In 1998, the DOH established a national structure for its reproductive health program. A tentative system of coordination between POPCOM and the service provider DOH is also being established. The Philippine Population Management Program was approved in March 1999 and is in line with ICPD goals and objectives as applied in the particular religious and cultural context of the Philippines.

The redefined program has five components: reproductive health and family planning; population and development; adolescent health and youth development; gender and women's development; and migration, population, and environment. Program policies are in accord with the Philippine constitution, which states: "Couples have the responsibility to decide how many children to have in accordance with their religious beliefs and the demands of responsible parenthood." The policies stress shared responsibility between men and women in achieving the desired number, spacing, and timing of children. The policies represent a shift from a demographic target-centered approach to a client-centered, integrated reproductive health approach.

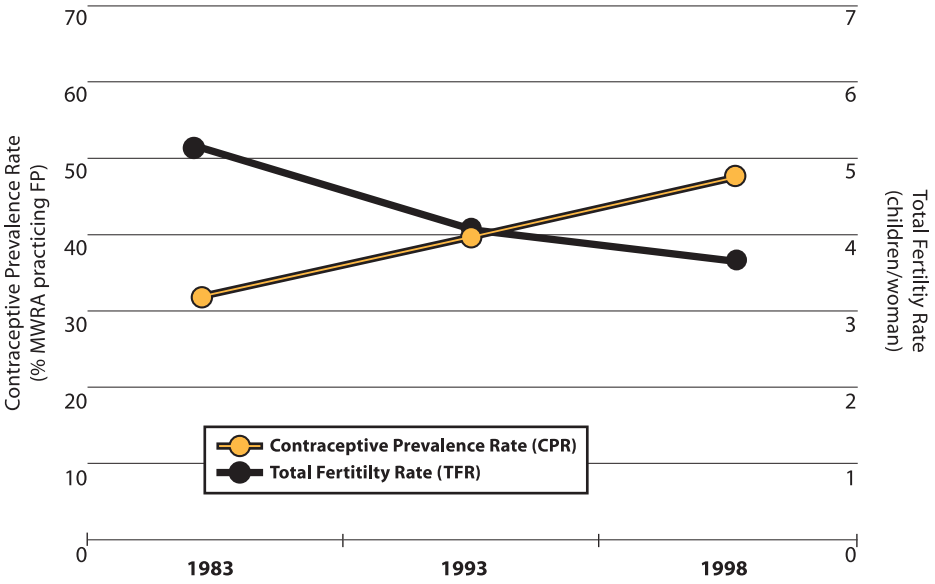
Institutionally, this shift has highlighted the important role of civil society groups in implementing the new program. This has led to viable partnerships with NGOs. New operating frameworks guiding the work of government agencies have also been adopted and are geared towards the local community level. Nonetheless, conditions at the local level remain far from the goal of universal access to reproductive health services, in part because the Philippines is predominantly Roman Catholic, and the Church's ban on birth control is at odds with the program.

Other Donors

The major bilateral donors to the Philippines include the United States, Australia, and Germany. USAID assistance aims at promoting economic transformation in the southern island of Mindanao, trade and investment, health and family planning, environmental management, and participation in public policy. It is also involved in policy work in capital market development. The Australian Agency for International Development mainly supports rural income generation, health, education, and the environment. Geographically, Australian assistance focuses on the southern Philippines, particularly Mindanao. Germany gives priority to natural resources management, vocational training, industrial and urban environmental management, maritime safety, and health and family planning. It is also active in promoting small- and medium-enterprise development. German assistance focuses on the Visayan region, with specific measures for Muslim Mindanao. Between 2000 and 2004, UNFPA will contribute $30 million to strengthen public- and private-sector reproductive health care services at national and local government levels and through selected NGOs. A combined World Bank-bilateral donor loan/grant program supports a five-year, $120 million Women's Health and Safe Motherhood Initiative.

Comments on this family planning/reproductive health country brief were not received from the Mission or Country Coordinator.

Contraceptive Prevalence and Total Fertility, 1983-1998



	1983	1993	1998
CPR (% MWRA)	32	40	47
TFR (child/woman)	5.1	4.1	3.7
Infant Mortality Rate (deaths/1,000 live births)		34	35

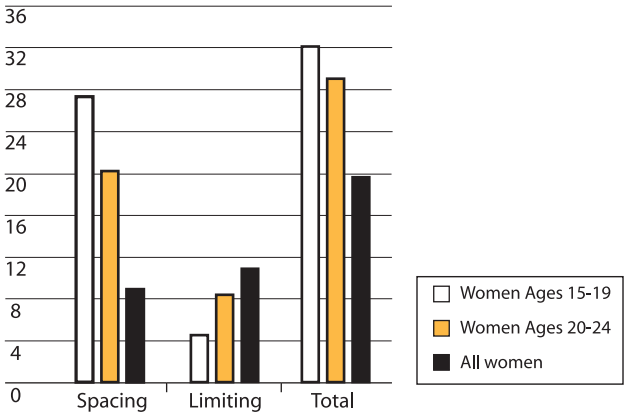
% Currently Married Women Using Family Planning by Method, 1993-1998

	1993	1998
Any Method	40.0	46.5
Traditional	15.1	18.3
Modern	24.9	28.2
Method Mix		
Pill	(F) 11.9 (M) 0.4	(F) 10.3 (M) 0.1
Oral contraceptives	8.5	9.9
Condom	1.0	1.6
Injectables	0.1	2.4
IUD	3.0	3.7

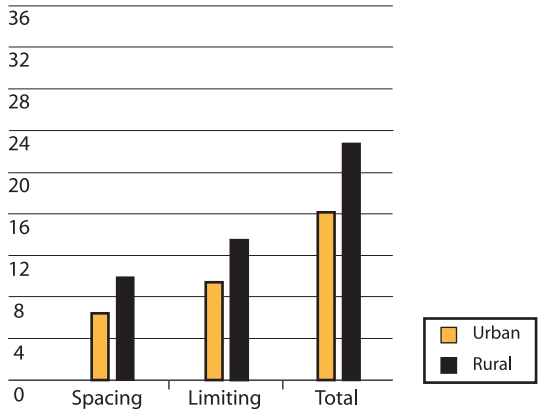
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

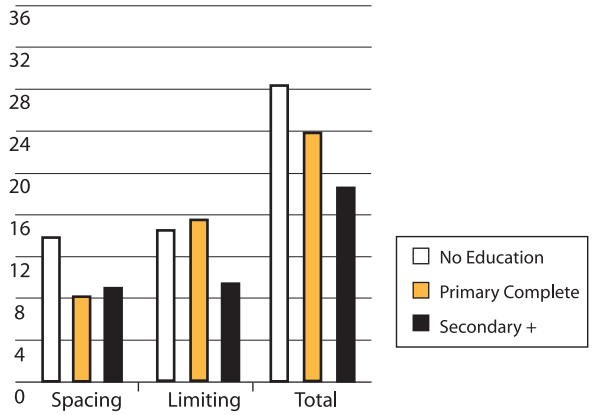
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Vietnam

Country Brief

USAID has provided more than $30 million in grants for humanitarian assistance to Vietnam since 1991. Legislation authorized the resumption of bilateral economic assistance in 1998, and in 2000 the United States ranked twelfth among 29 donors in the amount of assistance provided. USAID's office in Vietnam consists of two personal services contractors with oversight carried out by the USAID Cambodia Mission. The country is included in a number of global and regional initiatives, including assistance to war victims and other persons with disabilities, HIV/AIDS prevention and control, natural disaster mitigation, maternal and child health, injury prevention, and behavior change activities. Vietnam has a long history of government support for family planning to reduce population growth but faces the challenges of an economic slowdown, rural poverty, unemployment, and vulnerable populations, including war-disabled civilians, orphans, and groups at high risk for HIV/AIDS.

Indicators

Population	78.7 Million
Urban	24%
Crude Birth Rate	20 per 1,000
Crude Death Rate	6 per 1,000
Annual Growth Rate	1.5%
Adult Literacy Rate	Male: 96% Female: 91%
Government Agency for Population Policy	National Committee for Population and Family Planning
Maternal Mortality Ratio	96 per 100,000 live births[1]
Births Attended by Trained Health Personnel	77%
DHS Years	1997
Source of Family Planning Supplies	Public programs: 87.7% Private sector: 12.3%
Most Common Family Planning Method	Intrauterine Device

1 UNICEF 1999 reported maternal mortality at 160 per 100,000 live births.

Background

With a population of 78.7 million, Vietnam is the second largest country in Southeast Asia and the thirteenth largest in the world. Its people are young, well educated, and hard-working. It has the potential to become a significant trading partner and emerging market for U.S. products and services.

Following the Communist victory in 1975, Vietnam was closed to the world outside the Soviet bloc for more than 10 years. The country only reopened the door to the West in the late 1980s, when it also initiated a domestic economic reform and renewal program. The program yielded unprecedented levels of growth – an average 8 percent per year from 1990 to 1997 – in gross domestic product. It also made an impressive reduction in the proportion of the population living in acute poverty. According to a 1999 World Bank study, the percentage of the population living below the poverty line decreased from 58 to 37 percent between 1993 and 1998.

The World Bank study also reported that the country still had a long way to go. Most (76 percent) of the population is rural, and 45 percent of this population lives below the poverty level. Per capita income (US$338) remains very low. There are signs that the ability of the economy to absorb the growing labor force is weakening. Urban unemployment, for example, climbed from 5.9 percent in 1996 to 7.4 percent in 1999, while rural unemployment increased from 26.6 percent to around 30 percent during the same period. Infant mortality has declined to 36.7 deaths per 1,000 live births, but the proportion of malnourished children under 5 is a disturbingly high 37 percent. There are also a number of particularly vulnerable groups, including minorities in remote areas, victims of annual flooding, victims of war wounds or the mines left after the war, orphans and displaced children, and groups at high risk of contracting HIV/AIDS, particularly injection drug users and commercial sex workers.

The momentum of the last decade's economic success and development is now threatened from two sources. First, the regional financial crisis cut direct investment in Vietnam from foreign sources by half and caused sharp declines in export growth. Second, growth momentum has slowed as the vigor of reform has slackened and the growth impact of earlier reforms has faded. As a result, Vietnam by 2000 was experiencing relatively low annual economic growth of around 4 percent, leading to significant declines in employment, enterprise profitability, and public revenues. The decline in the economic growth rate also threatens the progress previously made in poverty reduction. To restore prior levels of economic growth, Vietnam will need to accelerate its economic reform program, modernize its economy, and become a competitive trading partner in the regional and world economy.

Vietnam's transitional economic status and its uncertainty about how to move from a socialist to a market economy are reasons for the United Sates to encourage and support the country's transition. USAID can play a significant role in helping Vietnam modernize, develop as a member of the world economy, and open and liberalize its markets by learning and adopting principles of democracy. USAID can also buttress health and humanitarian support to improve the quality of life for the poor and for disadvantaged groups such as the disabled, displaced children, populations susceptible to annual flooding, and populations at high risk of HIV/AIDS.

USAID Health Program and Strategies

In the context of a Management Framework covering FYs 2001-2003, USAID's program goals in Vietnam are to:

- Enhance the environment for trade and investment
- Improve access to services for selected vulnerable groups
- Improve urban/industrial environmental management

Although U.S. legislation prohibited most bilateral economic assistance to Vietnam until 1998, certain types of humanitarian assistance have been provided since 1991. USAID has provided grants to U.S. private voluntary organizations to provide prosthetics and rehabilitation services to civilian victims of war. In FY 1992, USAID's assistance was expanded to include humanitarian assistance to children and orphans. Special authorities also permit USAID to assist in commercial law and trade reform. In November 2000, USAID opened a new office in Hanoi staffed by two personal services contractors who report to the Regional USAID Mission in Cambodia. The current health and humanitarian assistance portfolio includes approximately $7 million of funding for activities in five areas – disabilities, HIV/AIDS, disaster mitigation, safe motherhood, and injury prevention. All assistance to Vietnam is provided in the context of obtaining the fullest possible accounting of prisoners of war and U.S. servicemen missing in action from the Vietnam War. In all, USAID has provided more than $30 million in grants since 1991.

National Health Policy and Plans

Vietnam was one of the first developing countries to adopt an official policy to reduce rapid population growth. As early as 1961, spurred by the results of the 1960 census, the government of North Vietnam issued a statement recommending that couples limit their family size and space their births to reduce the excessive rate of population growth. The policy was part of a strategy to enhance production during the struggle for independence and reunification and was apparently motivated by long-standing concerns about land pressures, chronic food shortages, and a desire to improve women's welfare.

Following reunification, policies to reduce population growth received increasing attention from the national government, and efforts to extend coverage of birth control services throughout the country gained greater priority. A series of government decisions and decrees led to the formal adoption in 1988 of a national policy advocating a family norm of one or two children. The 30 June 1989 National Health Law passed by the National Assembly legalized the "freedom of choice" principle for couples in their use of family planning practices. It stressed that individuals must be free to choose the family planning method they wished and prohibited "all acts of preventing or forcing the implementation of family planning."

In January 1993, the Communist Party Central Committee approved for the first time a resolution on population and family planning. In a strong statement, it identified excessive population growth as contributing to a wide range of social, economic, and ecological problems. The resolution endorsed the recommendation that "each family should have one or two children" so that fertility could be lowered and population stabilization achieved. In June 1993, the Prime Minister approved a comprehensive official plan – "Population and Family Planning Strategy to the Year 2000" – to guide efforts to implement the resolution.

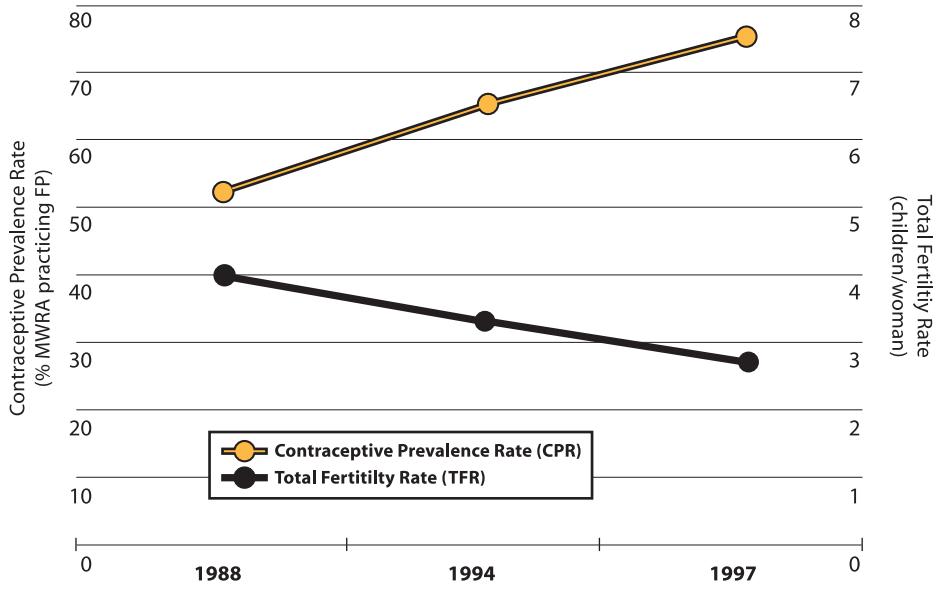
In late 2000 and early 2001, the Vietnamese government developed, approved, and began to implement new 10-year reproductive health and population strategies. The population strategy, as noted in the World Bank's 2000 *Vietnam Development Report,* "goes beyond the scope of the 1993 strategy to include new paradigms of the 1994 International Conference on Population and Development (ICPD) as well as ICPD+5. The strategy looks at population issues from a holistic perspective and includes reproductive health as an important strategy to achieve a harmonious balance between population dynamics and socioeconomic development in Vietnam." The new strategy makes an explicit commitment to substantially reducing abortions and doing away with coercive mechanisms to achieve population goals and recognizes that smaller families depend on informed choices and access to high-quality services and information. Similarly, the new reproductive health strategy calls for access to high-quality reproductive health services and information for all men, women, and adolescents by no later than 2010, with special attention to disadvantaged areas and people.

Other Donors

In 1998, after more than five years of decline, official development assistance (ODA) picked up by nearly 10 percent, and for the year Vietnam ranked eighth in international assistance among all countries receiving aid. Japan is the largest donor in Vietnam, disbursing $531 million in 1999, followed by the Asian Development Bank ($200 million), World Bank ($158 million), France ($71 million), and United Nations agencies ($52 million). The United States ranked 16th ($8.5 million) in donor contributions. ODA funds are increasingly oriented towards major infrastructure, particularly energy and transport. The largest percentage of UN agency support goes to health activities ($14.3 million) through UNICEF, UNFPA, and WHO technical assistance grants.

Comments on this family planning/reproductive health country brief were received from the USAID/Vietnam office on 9/27/01.

Contraceptive Prevalence and Total Fertility, 1988-1997



	1988	1994	1997
CPR (% MWRA)	53.2	65	75.3
TFR (child/woman)	4.0	3.3	2.7

% Currently Married Women Using Family Planning by Method, 1994-1997

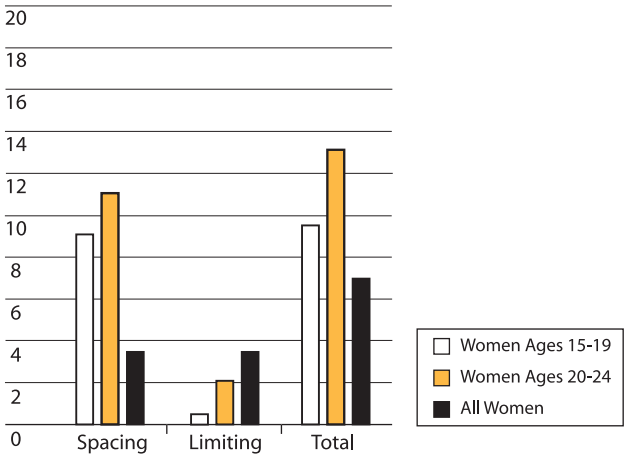
	1994	**1997**
Any Method	65	75.3
Traditional	21	19.2
Modern	44	56
Method Mix*		
Sterilization	(F) 3.9 (M) 0.2	(F) 6.3 (M) 0.5
Oral contraceptives	2	4.3
Condom	4	5.9
Injectables	0.2	0.2
Implants	N/A	N/A
IUD	33.3	38.5

** Source for 1994 method mix is Measure Communication.*

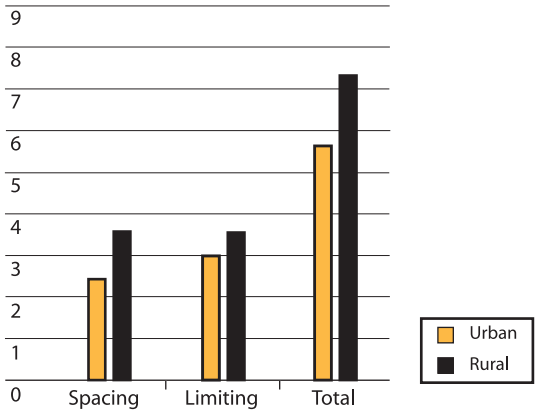
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

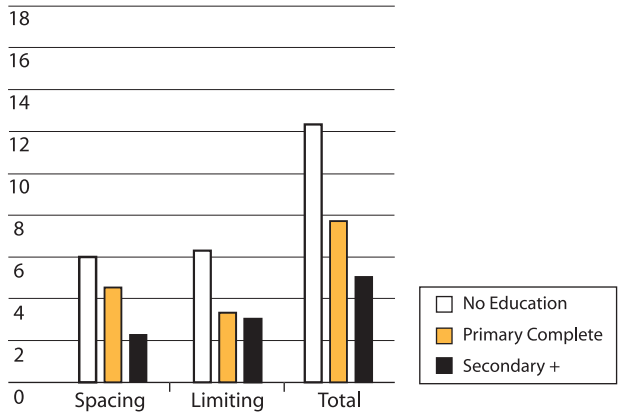
Unmet Need for by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

NEAR EAST

Egypt

Jordan

Morocco

West Bank & Gaza

Yemen

Egypt

Country Brief

For nearly three decades, USAID has been the leading donor in health and family planning activities in Egypt. From 1975 to 2000, USAID provided more than $500 million in health and population assistance. USAID's support for the government's family planning program helped the country achieve a decrease in fertility from 5.3 children per woman to 3.5 between the 1980 Egyptian Fertility Survey and the 2000 Egypt DHS. USAID continues to support health and family planning improvements and is also preparing for the transfer of program funding and management responsibilities to Egyptian organizations after USAID's assistance ends. Urban/rural disparities in health remain a challenge for Egypt and donor governments and agencies.

Indicators[1]

Population	65.1 Million
Urban	43%
Crude Birth Rate	27 per 1,000
Crude Death Rate	6.4 per 1,000
Annual Growth Rate	2.1%
Adult Literacy Rate	Male: 71% Female: 50%
Government Agency for Population Policy	National Population Council
Maternal Mortality Ratio	174 per 100,000 live births[2]
Births Attended by Trained Health Personnel	61%
DHS Years	N/A
Source of Family Planning Supplies	Public programs: 48.6% Private sector: 43.7% NGO sector: 7.3%
Most Common Family Planning Method	Intrauterine device

1 Source for population, crude birth and death rates, growth rate, and literacy is Egypt's Central Agency for Public Mobilization and Statistics.

2 MOHP 2000 Preliminary Results report a maternal mortality ratio of 94 per 100,000 births.

Background

For the past 25 years, the United States has supported Egypt's economic growth and development through major programs focused on infrastructure, social development, and macroeconomic reforms. U.S assistance has evolved through four overlapping phases. The first phase, from the mid–1970s to the early 1980s, focused on improving the country's physical infrastructure and included a major public–sector commodity import component. In the 1980s, with the rehabilitation of the country's physical infrastructure well underway, the second phase shifted the primary focus to health, family planning, education, and related areas. In the early 1990s, the third phase focused on the policy environment. The fourth phase began in 1994 with a new focus on trade and investment.

Since the 1980s, Egypt has continued to make notable progress in its social development, and USAID has made substantial contributions to this progress nationwide. In the health sector, child survival interventions have substantially reduced infant and child mortality and morbidity. Between 1988 and 1998, infant mortality declined from 74 to 44 deaths per 1,000 live births. The national immunization program has increased childhood immunization rates against six infectious diseases to 92 percent. An estimated 80,000 infant and child deaths are averted each year through USAID–financed child survival programs. In response to high maternal mortality reported in 1992 and 1993, USAID has supported efforts by the Ministry of Health and Population (MOHP) to improve obstetric care services in Upper Egypt. The government's voluntary family planning program, supported by USAID, has succeeded in lowering fertility from 5.3 children per woman in 1980 to 3.5 in 2000. It has also contributed to declines in morbidity and mortality for both mothers and children. USAID–financed family planning activities have provided Egyptian couples with rational information on reproductive health and increased the use of modern contraceptives from 23 percent in 1980 to 54 percent in 2000.

USAID Health Program and Strategies

The USAID health program falls under the Mission's second subgoal, *Sustaining the Human and Natural Resource Base.* It comprises strategic objectives in the areas of environmental and natural resource management, health and population, democratic governance and participation, and basic education.

Agency Goal 4, *World Population Stabilized and Human Health Protected,* is supported by the Mission's Strategic Objective (SO) 20 and its intermediate results (IRs):

SO 20: Healthier, Planned Families

IR 20.1: Increased use of family planning, reproductive health, and maternal and child health services by target populations

IR 20.2: Healthy behaviors adopted

IR 20.3: Sustainability of basic health services promoted

The main indicators of SO 20 success are targeted declines of 40 percent in the infant mortality rate (from 62.6 in 1995 to 37.5 in 2009) and 17 percent in the total fertility rate (from 3.6 in 1995 to 3.0 in 2009). Efforts focus on:

- Narrowing the gap in health and fertility status between Upper and Lower Egypt
- Reducing unmet need for family planning (11.4% in 2000)
- Improving the acceptability, convenience, and safety of reproductive, maternal, and child health services
- Implementing a national plan to prevent transmission of bloodborne pathogens, notably hepatitis C

- Targeting new HIV/AIDS prevention activities of nongovernmental organizations (NGOs) at high-risk groups

USAID has provided commodities, training, and technical and financial assistance to help these efforts remain on target. In partnership with mainly the MOHP, the Mission supports health and family planning improvements as well as preparations for a systematic transfer of funding and management responsibilities to Egyptian organizations (public and private) that will be able to sustain program achievements after the end of USAID funding. USAID also works in close cooperation with the Ministry of Information (health education and promotion), the Ministry of Insurance and Social Affairs (NGO programs), the Ministry of Higher Education (medical and nursing education), and the Ministries of Finance, Planning, and International Cooperation (phase–out and sustainability). NGO and commercial sector participation will increase significantly through the life of the SO. Major contractors and grantees implementing the activities are Pathfinder International, the U.S. Centers for Disease Control and Prevention, the U.S. Naval Medical Research Unit–3, the U.S. Department of Health and Human Services, the Program for Appropriate Technology in Health (PATH), UNICEF, and John Snow, Inc. In addition, USAID/Egypt participates in centrally managed USAID contracts with the Population Council, the Futures Group International, and Macro International, and (for contraceptives) with Leiras Pharmaceutical, Ortho–McNeil Pharmaceutical, Wyeth–Ayerst International Ltd., and Pharmacia.

National Health Policy and Plans

The Government of Egypt's goals and action plan are set forth in a statement called "Egypt & the 21st Century," more commonly known as the "2017 Vision." This statement emphasizes Egypt's critical role as a regional leader. It states explicitly that achieving the goals depends on the pivotal roles of the private sector, national will, and human development. Enhancing women's roles, dismantling traditional restrictions on women, conserving the environment and water, and achieving replacement-level fertility are key features of the vision. National goals include a legal and regulatory framework to support the vision, a greater role for an active and mature civil community, and increased development outside Cairo and the Nile Delta area. To reach the ambitious targets set forth in the "2017 Vision," the government will have to mobilize national resources, attract foreign investment while increasing the domestic savings rate, and encourage the private sector to become a major partner in development by increasing its share of the economy to 75 to 80 percent.

Other Donors

Donor assistance has played an important role in Egypt's development, with annual assistance flows in recent years averaging more than $2 billion from approximately 35 donors. The United States has long been the largest aid donor, followed by the European Union, Germany, the United Arab Emirates, Canada, the Scandinavian countries, Japan, France, Italy, and Arab agencies. The World Bank, the United Nations Development Programme, the International Monetary Fund, the International Finance Corporation, and other U.N. specialized agencies complement the efforts of these donors.

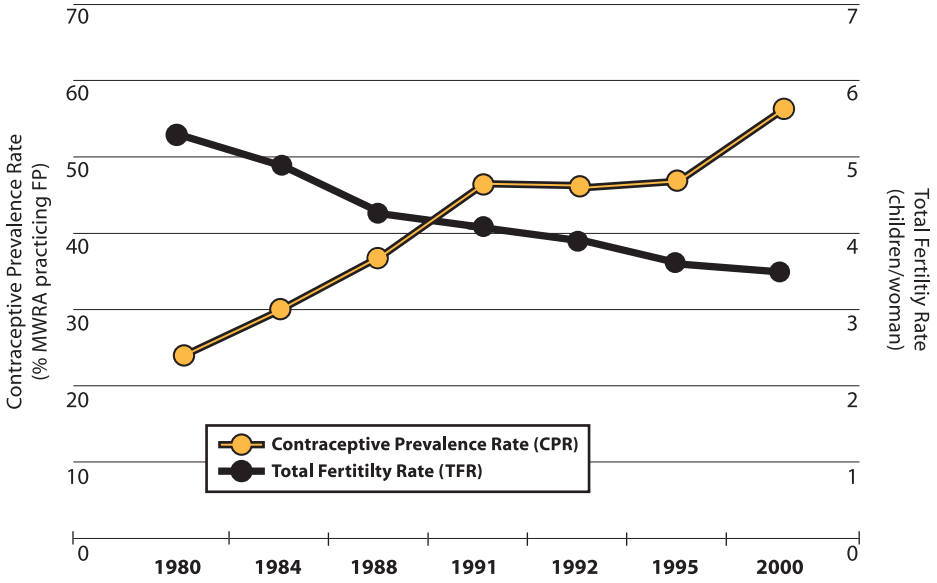
For nearly three decades, USAID has been the leading donor in health and population activities in Egypt, and it continues to be the leader today. The European Union is the second largest supporter of population and health, followed by Italy, France, Switzerland, and Japan. The World Bank lends substantially to the Egyptian government for social programs, including health and population. The United Nations agencies, especially UNFPA and UNICEF, provide valued assistance to programs addressing needs such as early childhood development, reproductive health education for youth, and women's health. The government's health sector reform partnership with the European Union, the World Bank, and USAID is achieving significant change in the health sector. Substantial support from WHO, the European Commission, the World Bank, UNICEF, UNFPA, and

for infectious disease surveillance and control, blood safety, maternal and child health services, and expanded access to voluntary family planning services.

Coordination is largely at the level of shared information with some parallel programming. Joint programming has not been tried in Egypt. Donors meet regularly to discuss common issues and exchange information to ensure programs are coordinated with and complement one another. Four focus groups were recently established to provide an integrated approach to social and economic development, governance, and the environment. Donor coordination will remain important during the plan period, as other donors such as the European Union and the World Bank take more prominent roles in promoting social and economic development.

Comments on this family planning/reproductive health country brief were received from the Mission on 9/24/01.

Contraceptive Prevalence and Total Fertility, 1980-2000



	1980	1984	1988	1991	1992	1995	2000
CPR (% MWRA)	24.2	30.3	37.8	47.6	47.1	47.9	56.1
TFR (child/woman)	5.3	4.9	4.4	4.1	3.9	3.6	3.5
Infant Mortality Rate (deaths/1,000 live births)	132		73		62	63	44

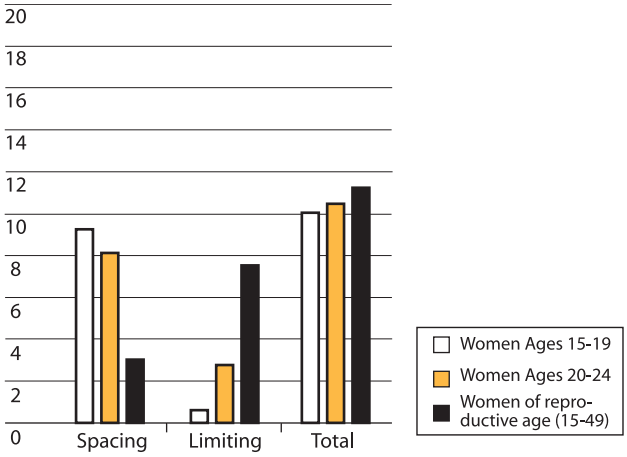
% Currently Married Women Using Family Planning by Method, 1995-2000

	1995	2000
Any Method	47.9	56.1
Traditional	2.4	2.2
Modern	45.5	53.9
Method Mix		23
Sterilization	(F) 1.1 (M) 0	(F) 1.4 (M) 0
Oral contraceptives	10.4	9.5
Condom	1.4	1.0
Injectables	2.4	6.1
Norplant	0.0	0.2
IUD	30	35.5

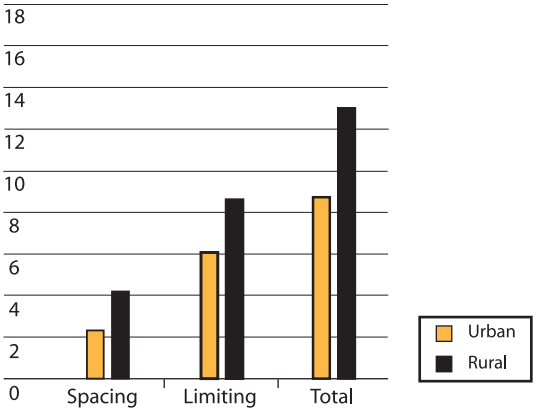
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

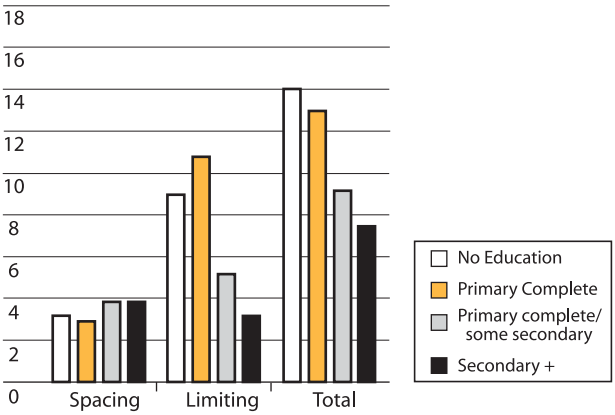
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Jordan

Country Brief

Since 1951, USAID has provided more than $2 billion in assistance to Jordan. USAID and the World Bank are the largest donors in population and family planning, and USAID has played a major role in helping Jordan establish and carry out its national family planning program. USAID's support focuses on behavior change and maintaining effective, sustainable health service delivery systems across the country. Despite strong progress in increasing contraceptive prevalence, Jordan still faces the challenge of rapid population growth, which continues to put pressure on the economic and social sectors.

Indicators

Population	5.2 Million
Urban	79%
Crude Birth Rate	27 per 1,000
Crude Death Rate	5 per 1,000
Annual Growth Rate	3.1%
Adult Literacy Rate	Male: 93% Female: 79%
Government Agency for Population Policy	National Population Council
Maternal Mortality Ratio	41 per 100,000 live births
Births Attended by Trained Health Personnel	96%
DHS Years	1990, 1997
Source of Family Planning Supplies	Public programs: 28% Private sector: 72%
Most Common Family Planning Method	IUD

Background

USAID/Jordan's economic assistance program is a vital component of U.S. Government efforts to promote peace and stability in the Middle East. Within Jordan, it provides important support during the transition to a post-King Hussein era. Within the region, it strengthens Jordan's moderating influence at a time when the final outcome of peace talks involving the Palestinian Authority, Syria, and perhaps eventually Lebanon is by no means clear.

The USAID/Jordan strategic construct is closely linked to the broader Embassy Mission Program Plan. First, USAID/Jordan's strategic plan addresses U.S. national security interests by supporting the Middle East peace process and promoting stability in a volatile region of the world. Second, the USAID/Jordan program promotes economic prosperity by encouraging trade and investment that could expand exponentially should true peace break out. Third, the USAID/Jordan program directly addresses several issues of global concern, including those related to health, population, and the environment.

Although Jordan has made substantial progress in reducing fertility, annual population growth (3.1 percent) remains high. Population momentum means that for at least another generation the country will face great pressure to meet the social and economic demands of an ever-increasing work force. If current trends continue, Jordan's population of 5.2 million will double to more than 10 million by 2027. The 1997 total fertility rate (TFR) of 4.4 children per woman, while substantially lower than the 1990 rate of 5.6, underscores the importance of continued USAID support in this area.

Jordan is entering a period of demographic transition marked by higher contraceptive use, lower fertility rates, and smaller families. USAID programs help promote this transition. The trend in modern contraceptive use, which increased from 27 percent of married women in 1990 to 39.8 percent in 1999, is encouraging. Surveys have pointed to changes in the attitudes of men and religious leaders that are helping to facilitate change in the country's demographic profile. These include a greater willingness to consider family planning and have fewer children.

USAID Health Program and Strategies

2001 marks the completion of half a century of USAID and predecessor agency assistance in Jordan. Total USAID funding provided to Jordan since 1951 is more than $2 billion.

The Mission Strategic Objective (SO) 3, Improved Access to and Quality of Reproductive and Primary Health, is supported by the following intermediate results (IRs):

IR 3.1: Increased knowledge of contraceptives

IR 3.2: Increased availability of reproductive and primary health care services in the public sector

IR 3.3: Progress in the commercial sector

IR 3.4: Increased rationalization of health financing systems

Public health has long been a USAID priority in Jordan. Early U.S. assistance was used to build and equip the central government laboratory, establish a tuberculosis center, launch Jordan's first school of nursing, and develop and expand immunization programs. Early U.S. support also helped eradicate malaria in Jordan. USAID has played a major role in helping the government establish and carry out a national family planning program. A long-term effort to improve maternal and child health care recently completed a nationwide network of 21 comprehensive postpartum (CPP) centers and primary health care centers. The last CPP center was established in early 2001.

Current USAID-funded activities in health and population build on these earlier programs. Activities support public awareness campaigns and other initiatives related to primary health care. Although it is too early to report

results, USAID has launched a $40 million health initiative based on "lessons learned" from the CPP centers. The initiative should have a significant impact on the Jordanian health sector over the next several years.

Efforts are also underway to identify and introduce new financing options aimed at ensuring the long-term financial sustainability of primary health care services, and policy work on health financing is underway. The basic premise for expanding USAID's population program to include broader health issues is that gains in family planning are contingent on maintaining an effective and sustainable health service delivery system across the country.

Current contractors and grantees include Johns Hopkins University, the U.S. Bureau of the Census, Abt Associates, Harvard University, Pathfinder International, the Futures Group International, Deloitte Touche Tohmatsu, the Academy for Educational Development, the U.S. Centers for Disease Control and Prevention, EngenderHealth, Family Health International, Macro International, and John Snow, Inc. Major host country partners include the Ministry of Health, Jordan University Hospital, the Royal Medical Services, the Department of Statistics, and nongovernmental organizations.

National Health Policy and Plans

The remarkable increase in modern contraceptive use to nearly 40 percent during the 1990s put Jordan well within range of the National Population Commission's target of 41.5 percent by 2000. Similarly, the TFR declined from an estimated 5.6 children per woman in 1990 to 4.4 in 1997. As part of a revision of the national population strategy, the Commission has raised the target contraceptive prevalence rate to 55 percent by 2015.

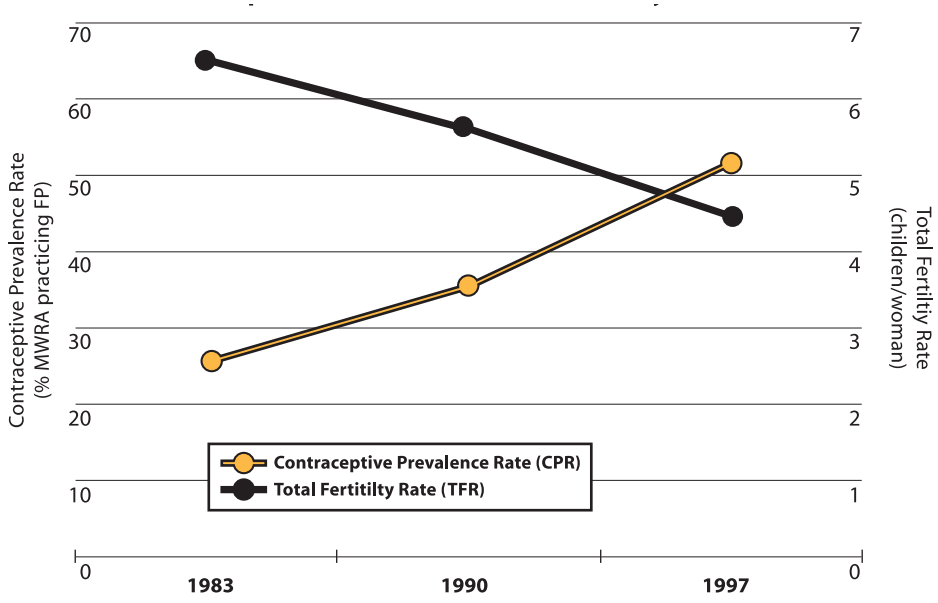
These positive trends have occurred in a policy environment in which the relationship between population growth and development and the impact of population growth on the government's social and economic aspirations for its citizens are increasingly recognized. For example, 1998 marked the first time that the Ministry of Planning considered population growth as one of the variables in developing its five-year development plan. The adoption of the country's first national population strategy in 1996 was an important achievement, given long-standing religious and cultural forces that traditionally have had a conservative influence. The population strategy is now being revised to include reproductive health and gender issues.

Other Donors

USAID and the World Bank remain the largest donors in the population and family planning sector. USAID programs are closely coordinated with those of other donors working in the population field, especially the World Bank, UNFPA (which has provided $4.5 million of support over five years), and the Japan International Cooperation Agency. The Ministry of Health provides necessary personnel and facilities for all program activities. In 1998, the Ministry contributed approximately $300,000 in commodities for hospitals collocated with USAID-funded CPP centers. Additionally, Jordan Television, in cooperation with the Ministry, provided $225,000 worth of prime-time advertising time for USAID-funded family planning infomercials.

Comments on this family planning/reproductive health country brief were not received from the Mission or Country Coordinator.

Contraceptive Prevalence and Total Fertility, 1983-1997



	1983	1990	1997
CPR (% MWRA)	26.0	35.0	52.6
TFR (child/woman)	6.6	5.6	4.4
Infant Mortality Rate (death/1,000 live births)		34	29

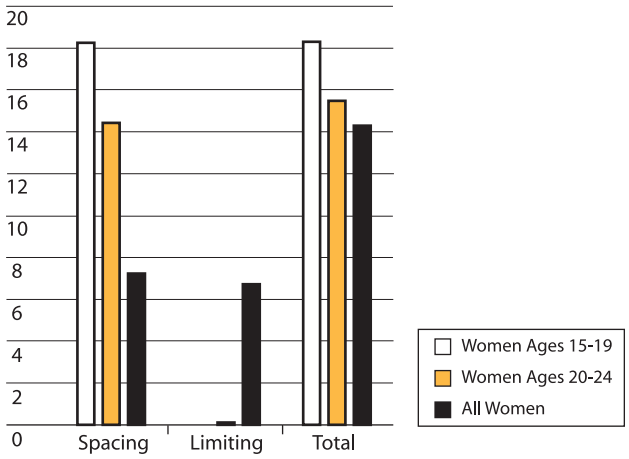
% Currently Married Women Using Family Planning by Method, 1990-1997

	1990	1997
Any Method	40	52.6
Traditional	13	14.8
Modern	27	37.7
Method Mix		
Sterilization	5.6	(F) 4.2 (M) 0
Pill	4.6	6.5
Condom	0.8	2.4
Injectables	N/A	0.7
Implants	N/A	0.1
IUD	15.3	23.1
Vaginal	0.6	0.5

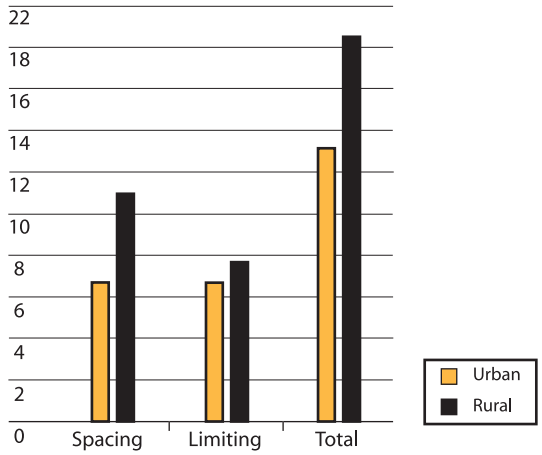
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

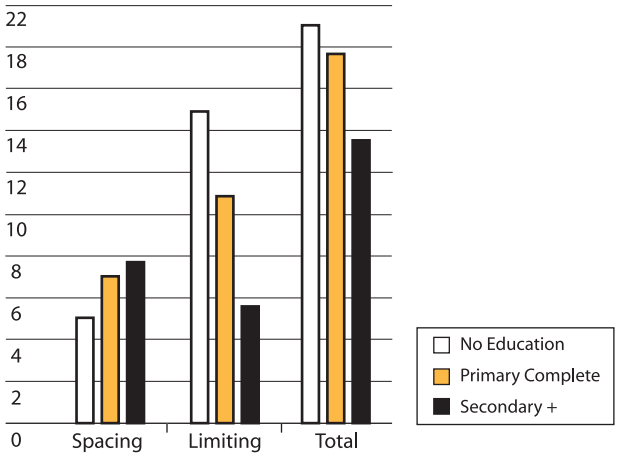
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

Morocco

Country Brief

After providing bilateral assistance to Morocco's Ministry of Health since 1970, USAID support for health and population has entered its final phase. USAID assistance has helped Morocco develop a highly successful family planning program with strong government commitment. Activities now focus on ensuring long-term sustainability through decentralized management of health services and private sector promotion. As a result of the phase-down of USAID support, the European Union has replaced USAID as the largest donor in Morocco's health sector. The country's family planning and health programs will continue to face the challenge of providing effective rural access to services.

Indicators

Population	29.2 Million
Urban	55%
Crude Birth Rate	25 per 1,000
Crude Death Rate	6 per 1,000
Annual Growth Rate	1.7%
Adult Literacy Rate	Male: 57% Female: 31%
Government Agency for Population Policy	Ministry of Health
Maternal Mortality Ratio	390 per 100,000 live births[1]
Births Attended by Trained Health Personnel	40%
DHS Years	1987, 1992, 1995, 1997[2]
Source of Family Planning Supplies	Public programs: 60% Private sector: 40%
Most Common Family Planning Method	Oral contraceptives

1 PAPCHILD Survey (1997) reports a maternal mortality ratio of 228/100,000 births.

2 Data from national PAPCHILD Survey (Arab League) equivalent to DHS, performed in 1997.

Background

The Kingdom of Morocco is a stable, lower-middle income country with about 29 million people. The country has enjoyed a modest growth rate over the past decade and continues to make economic progress. Structural adjustments have brought progress in macroeconomic stabilization, but high levels of poverty and illiteracy persist, especially among women (female illiteracy is 69 percent). Natural resources are scarce. Only 20 percent of the land is arable and, because of periodic drought, stable agriculture is dependent on irrigation.

Population growth and rural-urban migration are contributing to high unemployment and lack of access to housing, land, credit, and other productive resources. Women constitute 40 percent of the adult labor force, and their share of earned income is 28 percent. About 33 percent of girls and 44 percent of boys are enrolled in secondary school. Morocco spends 3.4 percent of its gross domestic product on health.

The most significant recent change in Morocco was the accession of King Mohamed VI to the throne in July 1999. This eliminated long-standing uncertainty about the former King Hassan's successor and the potential for unrest, which could have profoundly affected U.S. interests in this important yet troubled region. Since King Mohamed acceded the throne, changes in key ministries and other actions have sent clear signals of his commitment to transparency, democracy, economic development, and the rule of law. The new government has received a renewed mandate from King Mohamed to advance its policies on human rights, health care, education, and social development. This evolution reinforces Morocco's efforts to emerge as a more stable, democratic, and prosperous partner for the United States. Morocco's experiment in democracy is a fragile one, however, and the need for strong and continued U.S. support for the government's efforts has never been greater.

USAID Health Program and Strategies

The Mission Special Objective (SpO) 7, *Key Interventions Promote Sustainability of Population, Health, and Nutrition Programs,* is supported by the following intermediate results (IRs):

IR 7.1: Effective decentralization management of primary health care services established on a pilot basis

IR 7.2: Access to private-sector family planning/maternal and child health services increased nationwide

USAID's resources are targeted at promoting three out of six U.S. national interests listed in the Mission Performance Plan: open markets, broad-based economic growth, and democracy, with support for family planning linked to the goal of economic development. Activities under the previous (1995-2000) strategic health objective helped the government institutionalize its family planning/maternal and child health program and consolidate the program's gains. By the end of 2000, most of the necessary elements of a fully functioning national program were in place.

USAID and the Ministry of Health (MOH) are now focused on ensuring long-term program sustainability in light of considerably reduced donor resources. This is embodied in SpO 7, which flows from work under the previous health objective and focuses on the program elements deemed most critical for the sustainability of the national reproductive and child health program. This is intended to be the final phase of USAID assistance to the health sector and will operate outside the traditional bilateral context. It was designed through a participatory approach and reflects the broad consensus of MOH representatives, nongovernmental organizations, private sector associations, other donors, and beneficiaries about the issues facing Morocco's health sector over the next five years.

USAID's assistance under SpO 7 calls for greater involvement of new partners at the local level and in

the private sector in order to diversify the resource base and move problem solving from the central level closer to the local level. The focus on sustainability and phasing out is highlighted by the fact that funding levels are more than 70 percent lower than in previous agreements. The strategy calls for: 1) developing in two pilot regions (Souss-Massa-Draa and Tangier-Tetouan) a model for decentralizing management at the regional level, and 2) ensuring that the private sector provides a viable alternative to public sector provision of preventive health services. This approach is intended to provide new tools to address key barriers to sustainability by improving the management capacity of local players and ensuring the involvement of a range of partners both inside and outside the government. The strategy capitalizes on important opportunities that have opened in the policy arena as a result of the government's priority focus on decentralization, social equity, and health sector reform.

SpO 7 was approved in May 1999. The final work plan of the institutional contractor under the previous health objective, John Snow, Inc., was adjusted to facilitate the transition. In FY 2000, activities emphasized finalizing, closing out, and documenting key activities under the previous objective and ensuring a smooth transition to SpO 7. In collaboration with local partners, results packages and contractors were identified and established. Local partners include the MOH, John Snow, JHPIEGO, Management Sciences for Health, the Futures Group International, the International Sciences and Technology Institute, Abt Associates, Deloitte Touche Tohmatsu, and Population Services International.

National Health Policy and Plans

The Programme National de Planification Familiale was integrated into the process of economic and social development in 1966. The Moroccan government announced its support of family planning on the basis of reports of international organizations pointing out the effect of population growth on economic development. In 1976, the Ministry of Public Health created a division for developing population policy and central family planning services. Morocco has since achieved outstanding results in reducing fertility and improving the health of children under 5 years of age. In FY 1999, the success of the national family planning program was confirmed by a program audit undertaken by the Regional Inspector General's Office in Dakar and supported by a number of studies, including "Causes of Infant and Child Death in Morocco."

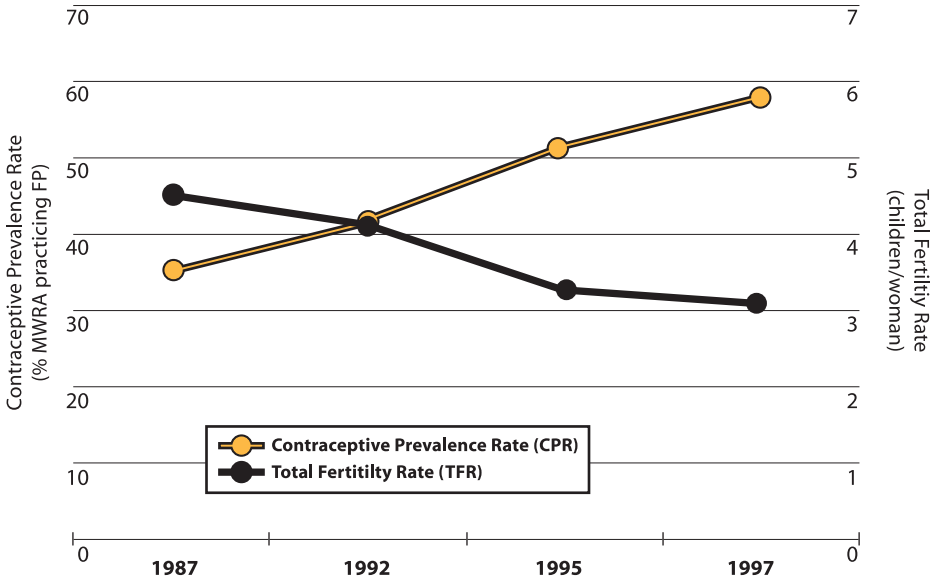
Nonetheless, important challenges remain. Contraceptive prevalence appears to have reached a plateau, with method mix heavily skewed toward oral contraceptives. Household survey data that show relatively high use of modern contraceptives in urban areas suggest that the leveling off of contraceptive use may be related to problems of access for Morocco's rural population (45 percent of the national population). The MOH is decentralizing responsibilities to the regional and provincial levels, giving them broader authority to identify and resolve problems using local approaches and resources. USAID has contributed to this initiative by working in five regions to develop a regional database and helping local partners design and implement activities to address key issues. This approach holds significant promise and probably represents the future of public-sector health management in Morocco.

Other Donors

Morocco remains heavily dependent on donors. Estimates indicate that more than 40 percent of the reproductive health program is donor-funded. In FY 2000, the European Union replaced USAID as the largest donor in the health sector. The World Bank plays a very significant role as a lender. UNICEF and UNFPA also play important roles, although UNFPA has recently suffered important budget constraints. USAID is working with the MOH to facilitate expansion of successful models by these donors as well as to establish links with private U.S. foundations, including the Bill & Melinda Gates Foundation, which has shown interest in funding a number of activities in Morocco.

Comments on this family planning/reproductive health country brief were received from the Mission on 09/19/01.

Contraceptive Prevalence and Total Fertility, 1987-1997



	1987	1992	1995	1997
CPR (% MWRA)	35.9	41.5	50.3	58.4
TFR (child/woman)	4.5	4.1	3.3	3.1
Infant Mortality Rate (deaths/1,000 live births)	73	57	62	37

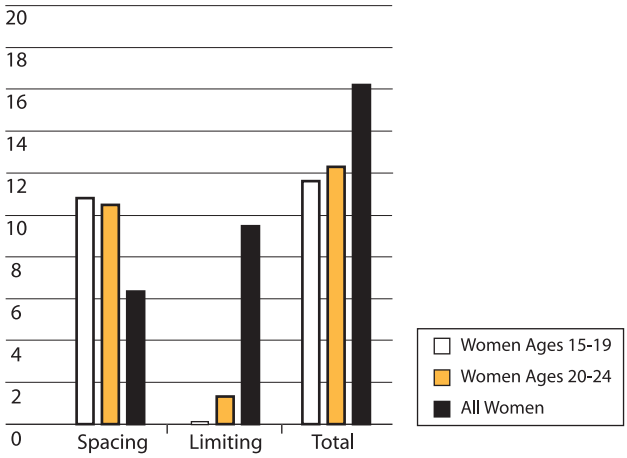
% Currently Married Women
Using Family Planning by Method, 1992-1997

	1992	1995	1997
Any Method	41.5	50.3	58.4
Traditional	5.6	7.9	10.1
Modern	35.5	42.4	48.3
Method Mix			(F) 3.0 (M) 0
Sterilization	(F) 3.0 (M) 0	(F) 4.3 (M) 0	38.3
Oral contraceptives	28.1	32.2	1.2
Condom	0.9	1.4	0.7
Injectables	0.1	0.1	0.1
Implants	0	0.1	5.3
IUD	3.2	4.3	2.7
Vaginal methods	0.2	0.1	

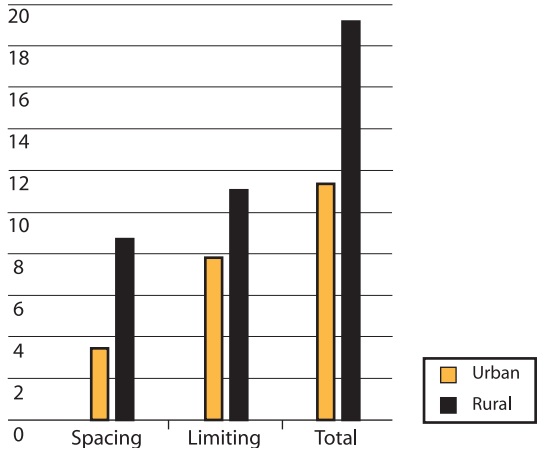
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

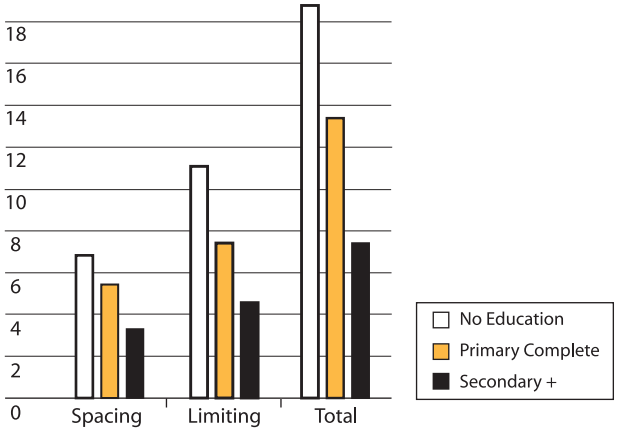
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

Population, % urban, crude birth and death rates: Population Reference Bureau (PRB) World Population Data 2001.
Annual growth rate: U.S. Bureau of the Census, International Database, 2000.
Literacy rates: PRB Women of the World Data 1998.

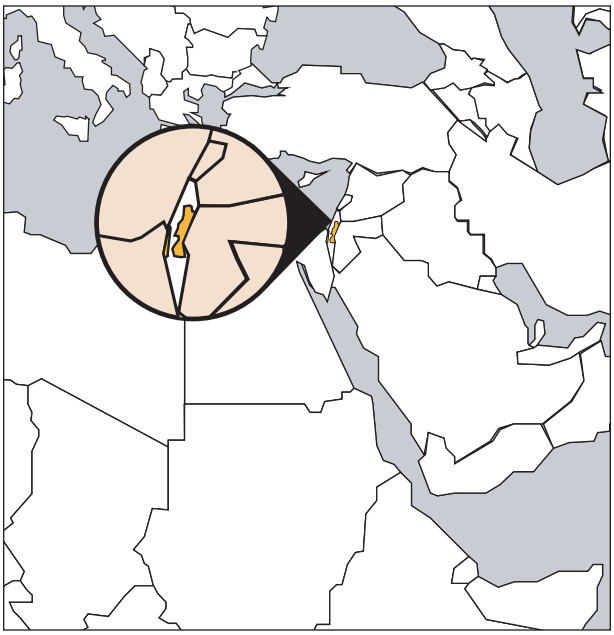
Maternal mortality ratio: Hill et al. *Estimates of maternal mortality for 1995:* WHO Bulletin, vol. 79, no. 3, 182-193.

Other indicators: DHS reports, most current year if no year specified. Trend data for TFR, CPR, and infant mortality may include data from national census or other source as reported in DHS. Infant mortality is reported for the 0- to 4-year period before the survey.

West Bank/Gaza

Country Brief

USAID's West Bank/Gaza health program began as a pilot project in 1999 with an initial obligation of $3.9 million. The project has upgraded clinics and provided training and is the only donor activity in West Bank/Gaza to provide concerted, integrated support for primary health care. The main challenge is the continuing political instability that restricts women's access to health services.



Indicators

Population	3.3 Million
Urban	N/A
Crude Birth Rate	42 per 1,000
Crude Death Rate	5 per 1,000
Annual Growth Rate	3.8%
Adult Literacy Rate	N/A
Government Agency for Population Policy	Women's Health and Development Directorate
Infant Mortality Rate	24 per 100,000 live births
Total Fertility Rate (children/women)	6
Contraceptive Prevalance Rate/All	51%
Contraceptive Prevalance Rate/Modern	37%
Most Common Family Planning Method	N/A

Background

The West Bank and Gaza are two geographically separated areas with a combined size of 6,000 square kilometers. About 25 percent of the West Bank population and 56 percent of the Gaza population are registered refugees. The political status of the West Bank and Gaza is subject to the principles of the Israeli–Palestine Interim Agreement signed in September 1993. The interim period has been characterized by complex peace negotiations. The Wye River negotiations, held in October 1998, revived the Palestinian–Israeli peace process and provided funding for development assistance.

The latest violence in the West Bank and Gaza has altered the political, economic, and social circumstances facing Palestinians. Deteriorating security conditions and the closures of Israeli, West Bank, and Gaza crossing points have rendered large areas of the West Bank and Gaza inaccessible to USAID and expatriate contractor staff. They have also halted or severely restricted the delivery of supplies and equipment to many USAID project sites. In response to the changed circumstances and their potential impact on the management and implementation of the USAID West Bank/Gaza program, the Mission is in the process of developing a transition plan. The plan does not anticipate discontinuing activities under the health strategic objective.

USAID Health Program and Strategies

The Mission Strategic Objective (SO) 7, Healthier Palestinian Families, is supported by the following intermediate results (IRs):

IR 7.1: Improved timing of births

IR 7.2: Improved reproductive health

IR 7.3: Infant and child health and nutrition

IR 7.4: Increased ability to address selected health problems affecting Palestinian families

The health program began as a pilot project in the third quarter of FY 1999 under Special Strategic Objective (SpO) 2, Selected Development Needs Addressed, and therefore was not evident in the 1996–2000 Country Strategy dated March 1996. The initial obligation was approximately $3.9 million for the two-year project.

The strategy of the two-year pilot health project was to improve the health status of mothers and children, especially newborns. It identified the following problems:

- Extremely limited coverage of antenatal and postpartum care systems, with perinatal care identified as the weakest
- High fertility rates and closely spaced births
- A highly stressed health system unable to provide adequate care

The Mission is currently developing an expanded health program to increase assistance to rural and village health clinics.

National Health Policy and Plans

The Palestinian Authority's Ministry of Health is committed to the goal of "health care for all" through the delivery of primary health care, which is provided at 261 sites. Fourteen hospitals deliver secondary care. A 250-bed hospital in Jerusalem provides tertiary care. The national health policy and plan contains specific objectives for improving women's reproductive health and reducing maternal mortality and morbidity.

The Ministry has established the Women's Health and Development Directorate with the responsibility of developing and monitoring the implementation of reproductive health policies in coordination with nongovernmental organizations (NGOs). The Palestinian Authority has established the Palestinian Central Bureau of Statistics and developed a master plan for official statistics.

Other Donors

Other donor governments and institutions are involved in the health sector, but their efforts tend to be directed at national health policy issues and broad strengthening of the Palestinian Authority Ministry of Health. The Government of Japan and the European Union, the two largest donors in this area, primarily fund equipment and construction of health care facilities. No other donor is working in primary health care on a concerted, integrated basis.

The primary implementing organizations for USAID are CARE International and the Population Council. They have entered into subagreements with five Palestinian organizations. The two-year pilot project will be implemented in three regions and test selected interventions for expanding and improving maternal and child health and family planning education and services. Clinical, outreach, and management systems will be upgraded.

Other agencies providing health services include:

- The Palestinian Authority, which works through the Ministry of Health, the United Nations Relief and Works Agency (UNRWA), NGOs, and the commercial sector.
- UNRWA, which provides health services to refugees in 22 primary health care clinics in West Bank, 17 in Gaza, and one hospital. UNRWA purchases secondary and tertiary services from the Ministry of Health, NGOs, and Israeli hospitals. Reproductive health and family planning are priority concerns. Contraceptive prevalence in West Bank/Gaza is highest in UNRWA-serviced areas.
- NGOs, which serve communities not covered by the Ministry of Health or UNRWA. Twelve hospitals provide secondary services.
- The Patient Friends Society, which offers primary health care and medical services in the Jenin area.
- The Union of Palestinian Medical Relief Committees, which is active in both the West Bank and Gaza. The Union has strong central management and can muster volunteer medical services. The committees offer comprehensive maternal/child health and family planning services. Clinics have community health workers who provide education, motivation, and follow-up services.
- The Union of Health Work Committees, which has district affiliates and a private nonprofit hospital in Gaza. It uses community health workers to provide maternal/child health and family planning services.
- The Health Development, Information, and Policy Institute, which focuses on primary health care including maternal and child health.
- The Center for Development in Primary Health Care, which is dedicated to improving primary health care and conducts regular training courses for health personnel.
- The for-profit sector, which has 160 private clinics in the West Bank and a few in Gaza. This sector is rapidly expanding as more doctors enter private practice.

Data sources: U.N. World Population Prospects, 2000; Population Reference Bureau World Population Data, 2001.

Comments on this family planning/reproductive health country brief were not received from the Mission or Country Coordinator.

Yemen

Country Brief

USAID has not had a mission in Yemen since October 1996. Between 1996 and September 2000, USAID provided assistance through regional activities administered by USAID/Cairo and managed by Yemeni nationals. Since October 2000, the U.S. Embassy in Sanaa has overseen the management of the USAID program in Yemen. U.S. assistance is minor, and the World Bank is by far Yemen's largest donor. USAID activities focus on strengthening institutional capacity by improving management and technical skills and by providing clinical equipment. Although democracy is growing stronger in Yemen, a weak human resource base, a declining economy, poverty, and a population growth rate of more than 3 percent present major challenges to the country's development.

Indicators

Population	18 Million
Urban	26%
Crude Birth Rate	44 per 1,000
Crude Death Rate	11 per 1,000
Annual Growth Rate	3.4%
Adult Literacy Rate	50.5
Government Agency for Population Policy	Central Statistical Organization, Ministry of Planning and Development Ministry of Public Health & Population National Population Council
Maternal Mortality Ratio	850[1] per 100,000 live births
Births Attended by Trained Health Personnel	22%
DHS Years	1992, 1997
Source of Family Planning Supplies	Public programs: 49% Private sector: 48%
Most Common Modern Family Planning Method	Oral contraceptives

1 The Ministry of Public Health reports estimate MMR from 1,000 to 1,400 per 100,000.

Background

In May 1990, North Yemen and South Yemen united to form the Republic of Yemen. Yemeni leaders declared a democratic society with a multiparty political system, a free press, and a broadening of individual freedoms. Shortly thereafter, the Gulf crisis erupted, resulting in the severance of Saudi and Kuwaiti aid and severe reductions in aid from Western donors, including the United States. Still, Yemen proceeded with a remarkable democratization process and conducted a free, fair, and representative election in April 1993. The economic effects of the Gulf crisis, combined with government mismanagement, sharply worsened Yemen's economic plight, however, and reduced its capacity to provide services to its citizens. Internal dissatisfaction led to political infighting and a two-month civil war in mid-1994. At the war's end, Yemen was once again united as a democratic nation, but its economy was shattered.

Yemen suffers from a weak human resource base and widespread poverty. It is the most populous country on the Arabian Peninsula and one of the world's 25 poorest and least developed countries. Adult literacy is approximately 50 percent, and infant and maternal mortality are among the highest in the world. Although life expectancy at birth has increased from 46.3 years to 59.8 years, it is still far below the average for the Middle East/North Africa region. Yemen's fertility rate, at 6 children per woman, is also one of the highest in the world, and the population is currently growing at a rate of 3.5 percent per year.

While Yemen's stature as a young democracy grows, its economy continues to decline. The quality of health, social, and economic services has seriously declined as the population has continued to grow. The weak institutional capacity of Yemen's ministries and development agencies are becoming more evident as they grapple with ever-worsening problems. Since the end of the civil war, the Yemeni government has taken a more realistic look at its economic problems and institutional weaknesses and is clearly more receptive to donor assistance in addressing these needs.

USAID Health Program and Strategies

There is currently no USAID mission in Yemen, but activities are ongoing as part of regional activities administered by the U.S. Embassy. U.S. government priorities focus on democratization and economic development and will continue to support the strengthening of a multiparty parliament, improvements in the judicial and legal systems, and increased effectiveness of the electoral system.

U.S. assistance is also targeting reproductive and maternal health, education, and human resource development. The Mission Strategic Objective (SO) 1, *Increased Management Capacity in Delivery and Quality of Health Care Services - Yemen Ministry of Public Health & Population (MOPH&P),* is supported by the following intermediate results (IRs):

IR 1.1: Upgraded management skills of hospital/health administrators and MOPH&P staff

IR 1.2: Upgraded management skills of midlevel MOPH&P administrators and staff

IR 1.3: Upgraded technical skills of paraprofessionals

In addition, USAID has assisted the Yemeni public health services with commodity support for maternal and child health through the Options for Family Care project. The project has procured clinical equipment to support maternal/child health service delivery in 29 health centers. The centers, located in 14 governorates, were selected by the MOPH&P based on critical need for upgraded health equipment. The criteria used in selecting the centers were availability of female health staff; availability of space for providing maternal/child health services, including family planning services; a lack of other agencies providing medical equipment; readiness to maintain medical equipment; and location in an area with a population of more than 10,000.

National Health Policy and Plans

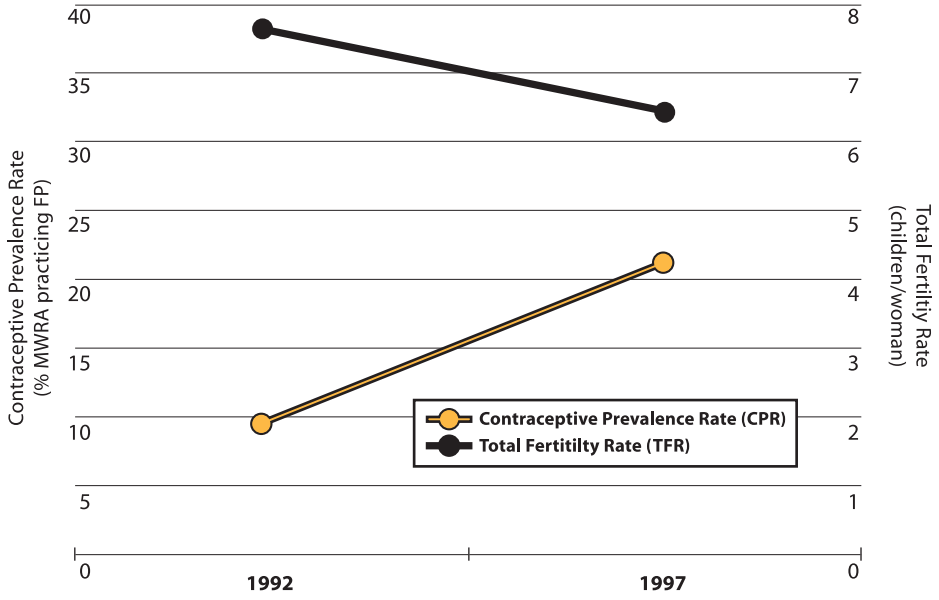
In October 1991, following years of debate and campaigning by various agencies, Yemen adopted an official population policy and established the National Population Commission. Targets include increasing the contraceptive prevalence rate to 35 percent and integrating family planning and maternal/child health care while achieving overall improvements in primary health care. The government will have to remain committed to family planning to achieve efficient distribution and service delivery in remote areas.

Other Donors

The World Bank is by far the largest donor, followed by the Netherlands, Japan, and Germany. The Bank focuses on public sector management, including civil service reform, budget reform, privatization, diversification of private investment, water management, and poverty–oriented social sector improvements, particularly basic education for girls. Most assistance from other donors supports the latter two areas, as all major donors recognize the importance of water management, health, and education. This leaves the World Bank almost alone in helping the government improve public sector management and create an attractive environment for private investment.

Comments on this family planning/reproductive health country brief were received from the Mission on 10/30/01.

Contraceptive Prevalence and Total Fertility, 1992-1997



	1992	1997
CPR (% MWRA)	9.7	20.8
TFR (child/woman)	7.7	6.5
Infant Mortality Rate (deaths/1,000 live births)	83	75

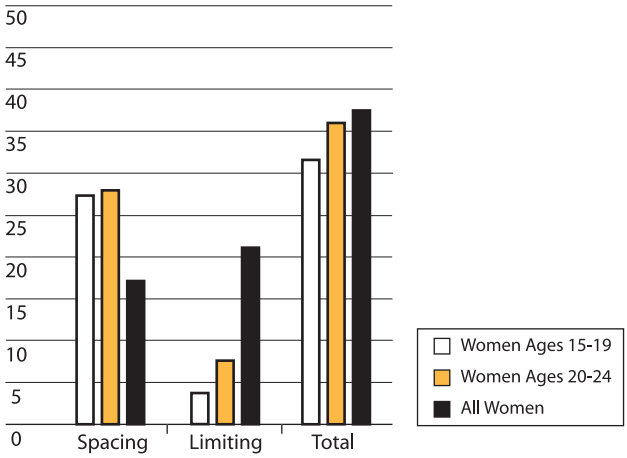
% Currently Married Women Using Family Planning by Method, 1992-1997

	1992	1997
Any Method	9.7	20.8
Traditional	3.6	10.8
Modern	6.1	9.8
Method Mix		
Sterilization	(F) 0.8 (M) 0.1	(F) 1.4 (M) 0.1
Vaginal	N/A	0.1
Condom	0.1	0.3
Injectables	0.6	1.2
Oral contraceptives	3.2	3.8
IUD	1.2	3.0

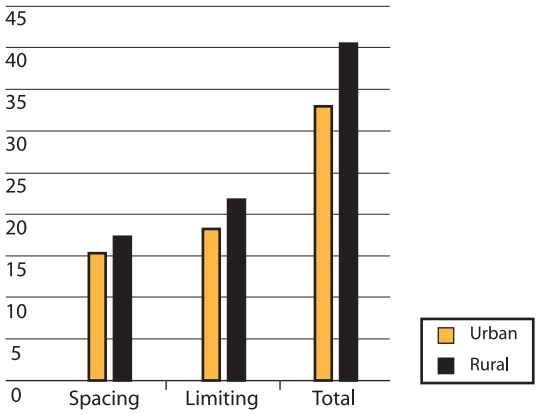
Unmet Need for Family Planning

The percentage of MWRA at risk of pregnancy who do not want any more children or want to postpone the next birth for two years or more but who are not presently using any method of contraception

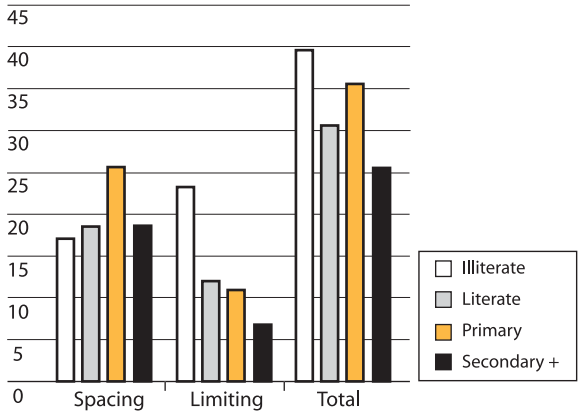
Unmet Need by Age



Unmet Need by Urban/Rural Residence



Unmet Need by Education



Data sources:

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This document was prepared by USAID in conjunction with the Population, Health and Nutrition Information Project under contract HRN-C-00-00-00004-00.